Title 388 WAC

SOCIAL AND HEALTH SERVICES, DEPARTMENT OF

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Chapter 388-06 WAC
BACKGROUND CHECKS

WAC

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WAC 388-06-0010 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules for background checks conducted by children's administration (CA), and the division of developmental disabilities (DDD) at the department of social and health services (DSHS). The department does background checks on individuals who are licensed, certified, contracted, or authorized to care for or have unsupervised access to children and to individuals with a developmental disability. Background checks are conducted to find and evaluate any history of criminal convictions or civil adjudication proceedings, including those involving abuse, abandonment, financial exploitation, or neglect of a child or vulnerable adult.

(2) This chapter also defines when the one hundred twenty-day provisional hire is allowed by DSHS. WAC 388-06-0500 through 388-06-0540 apply to all DSHS administrations.

(3) WAC 388-06-0600 through 388-06-0640 of this chapter includes the background check requirements for

DSHS employees and applicants seeking, working or serving in a covered position.

(4) WAC 388-06-0700 through 388-06-0720 of this chapter describes the responsibilities of the background check central unit.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0010, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0010, filed 1/8/09, effective 2/8/09. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0010, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0020 What definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter? The following definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter:

"Authorized" or **"authorization"** means not disqualified by the department to have unsupervised access to children and individuals with a developmental disability. This includes persons who are certified, contracted, allowed to receive payments from department funded programs, or volunteer.

"CA" means children's administration, department of social and health services. Children's administration is the cluster of programs within DSHS responsible for the provision of licensing of foster homes, group facilities/programs and child-placing agencies, child protective services, child welfare services, and other services to children and their families.

"Certification" means:

(1) Department approval of a person, home, or facility that does not legally need to be licensed, but wishes to have evidence that they met the minimum licensing requirements.

(2) Department licensing of a child-placing agency to certify and supervise foster home and group care programs.

"Children" and **"youth"** are used interchangeably in this chapter and refer to individuals who are under parental or department care including:

(1) Individuals under eighteen years old; or

(2) Foster children up to twenty-one years of age and enrolled in high school or a vocational school program; or

(3) Developmentally disabled individuals up to twenty-one years of age for whom there are no issues of child abuse and neglect; or

(4) JRA youth up to twenty-one years of age and who are under the jurisdiction of JRA or a youthful offender under the jurisdiction of the department of corrections who is placed in a JRA facility.

"Civil adjudication proceeding" is a judicial or administrative adjudicative proceeding that results in a finding of, or upholds an agency finding of, domestic violence, abuse, sexual abuse, neglect, abandonment, violation of a professional licensing standard regarding a child or vulnerable adult, or exploitation or financial exploitation of a child or vulnerable adult under any provision of law, including but not limited to chapter 13.34, 26.44 or 74.34 RCW, or rules adopted under chapters 18.51 and 74.42 RCW. "Civil adjudication proceeding" also includes judicial or administrative findings that become final due to the failure of the alleged perpetrator to timely exercise a legal right to administratively challenge such findings.

"DCFS" means division of children and family services and is a division within children's administration that provides child welfare, child protective services, and support services to children in need of protection and their families.

"DDD" means the division of developmental disabilities, department of social and health services (DSHS).

"DLR" means the division of licensed resources that is a division within children's administration, the department of social and health services.

"Department" means the department of social and health services (DSHS).

"I" and **"you"** refers to anyone who has unsupervised access to children or to persons with developmental disabilities in a home, facility, or program. This includes, but is not limited to, persons seeking employment, a volunteer opportunity, an internship, a contract, certification, or a license for a home or facility.

"JRA" means the juvenile rehabilitation administration, department of social and health services.

"Licensor" means an employee of DLR or of a child placing agency licensed or certified under chapter 74.15 RCW to approve and monitor licenses for homes or facilities that offer care to children. Licenses require that the homes and facilities meet the department's health and safety standards.

"Individuals with a developmental disability" means individuals who meet eligibility requirements in Title 71A RCW. A developmental disability is any of the following: Intellectual disability, cerebral palsy, epilepsy, autism, or another neurological condition described in chapter 388-823 WAC; originates before the age of eighteen years; is expected to continue indefinitely; and constitutes a substantial limitation to the individual.

"Spousal abuse" includes any crime of domestic violence as defined in RCW 10.99.020 when committed against a spouse, former spouse, person with whom the perpetrator has a child regardless of whether the parents have been married or lived together at any time, or an adult with whom the perpetrator is presently residing or has resided in the past.

"Unsupervised" means not in the presence of:

(1) The licensee, another employee or volunteer from the same business or organization as the applicant who has not been disqualified by the background check.

(2) Any relative or guardian of the child or developmentally disabled individual or vulnerable adult to whom the applicant has access during the course of his or her employment or involvement with the business or organization (RCW 43.43.080(9)).

"Unsupervised access" means that an individual will or may be left alone with a child or vulnerable adult (individual with developmental disability) at any time for any length of time.

"We" refers to the department, including licensors and social workers.

"WSP" refers to the Washington state patrol.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0020, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0020, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0110 Who must have background checks? (1) Per RCW 74.15.030, the department requires background checks on all providers who may have unsupervised access to children or individuals with a developmental disability. This includes licensed, certified or contracted providers, their current or prospective employees and prospective adoptive parents as defined in RCW 26.33.020.

(2) Per RCW 74.39A.055, the department requires state and federal background checks on all long-term care workers for the elderly or persons with disabilities hired or contracted after January 1, 2012.

(a) This does not include long-term care workers qualified and contracted or hired on or before December 31, 2011.

(b) Parents are not exempt from the long-term care background check requirements.

(3) Per RCW 74.15.030, the department also requires background checks on other individuals who may have unsupervised access to children or to individuals with a developmental disability in department licensed or contracted homes, or facilities which provide care. The department requires background checks on the following people:

(a) A volunteer or intern with regular or unsupervised access to children;

(b) Any person who regularly has unsupervised access to a child or an individual with a developmental disability;

(c) A relative other than a parent who may be caring for a child;

(d) A person who is at least sixteen years old, is residing in a foster home, relatives home, or child care home and is not a foster child.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0110, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 43.43.832, 26.33.190, 26.44.030, 74.15.030, 2007 c 387 and Adam Walsh Act of 2006. 09-06-028, § 388-06-0110, filed 2/24/09, effective 3/6/09. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0110, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0130 Does the background check process apply to new and renewal licenses, certification, contracts, and authorizations to have unsupervised access to children or individuals with a developmental disability? (1) For children's administration these regulations apply to all applications for new and renewal licenses, contracts, certifications, and authorizations to have unsupervised access to children or individuals with a developmental disability that are processed by the children's administration after the effective date of this chapter.

(2) For the division of developmental disabilities these regulations apply to any of the following that may involve unsupervised access to children and individuals with a developmental disability:

(a) Initial contracts, licenses or certifications and renewals as required by the applicable DDD background check renewal schedule and program regulations; and

(b) Any contract, license or certification renewal when there was a lapse of one day or more following expiration.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0130, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0130, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0150 What does the background check cover? (1) The department must review criminal convictions and pending charges based on identifying information provided by you. The background check may include but is not limited to the following information sources:

(a) Washington state patrol.

(b) Washington courts.

(c) Department of corrections.

(d) Department of health.

(e) Civil adjudication proceedings.

(f) Applicant's self-disclosure.

(g) Out-of-state law enforcement and court records.

(2) Except as required in WAC 388-06-0150 (4)(b) and (5), children's administration and division of developmental disabilities will conduct a fingerprint-based background check on any individual who has lived in Washington state for less than three years.

(3) Background checks conducted for children's administration also include:

(a) A review of child protective services case files information or other applicable information system.

(b) Administrative hearing decisions related to any DSHS license that has been revoked, suspended, or denied.

(4) In addition to the requirements in subsections (1) through (3) of this section, background checks conducted by children's administration for placement of a child in out-of-home care, including foster homes, adoptive homes, relative placements, and placement with other suitable persons under chapter 13.34 RCW, include the following for each person over eighteen years of age residing in the home:

(a) Child abuse and neglect registries in each state a person has lived in the five years prior to conducting the background check.

(b) Washington state patrol (WSP) and Federal Bureau of Investigation (FBI) fingerprint-based background checks regardless of how long you have resided in Washington.

(5) The division of developmental disabilities requires fingerprint-based background checks for all long-term care workers as defined in RCW 74.39A.009(16) hired or contracted on or after January 1, 2012. These background checks must include a review of conviction records through the Washington state patrol, the Federal Bureau of Investigation, and the national sex offender registry.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0150, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 43.43.832, 26.33.190, 26.44.030, 74.15.030, 2007 c 387 and Adam Walsh Act of 2006. 09-06-028, § 388-06-0150, filed 2/24/09, effective 3/6/09. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0150, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0160 Who pays for the background check? (1) Children's administration (CA) pays the DSHS general administrative costs for background checks for foster home applicants, CA relative and other suitable caregivers, and CA adoptive home applicants.

(2) Children's administration pays the WSP and FBI-fingerprint processing fees for foster home applicants, CA relative and other suitable caregivers, CA adoptive home applicants, and other adults associated with the home who require background clearances under chapter 13.34 RCW.

(3) Children's administration does not pay WSP and FBI fingerprint processing fees or expenses for employees, contractors, or volunteers associated with facilities other than foster homes.

(4) The division of developmental disabilities pays for background checks, including fingerprint-based background checks, for individuals seeking authorization to provide services to clients of the division.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0160, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 43.43.832, 26.33.190, 26.44.030, 74.15.030, 2007 c 387 and Adam Walsh Act of 2006. 09-06-028, § 388-06-0160, filed 2/24/09, effective 3/6/09. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0160, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0180 Are there other criminal convictions that will prohibit me from working with children or individuals with a developmental disability? The department must disqualify you from licensing, contracting, certification, or from having unsupervised access to children or to individuals with a developmental disability if it has been less than five years from a conviction for the following crimes:

(1) Any physical assault not included in WAC 388-06-0170;

(2) Any sex offense not included in WAC 388-06-0170;

(3) Any felony conviction not included in WAC 388-06-0170; or

(4) Felony violation of the following drug-related crimes:

(a) The Imitation Controlled Substances Act (for substances that are falsely represented as controlled substances (see chapter 69.52 RCW));

(b) The Legend Drug Act (prescription drugs, see chapter 69.41 RCW);

(c) The Precursor Drug Act (substances used in making controlled substances, see chapter 69.43 RCW);

(d) The Uniform Controlled Substances Act (illegal drugs or substances, see chapter 69.50 RCW); or

(e) Unlawfully manufacturing, delivering or possessing a controlled substance with intent to deliver, or unlawfully using a building for drug purposes.

(5) Any federal or out-of-state conviction for an offense that under the laws of Washington state would disqualify you for no less than five years from having unsupervised access to children or individuals with a developmental disability.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0180, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0180, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0250 Is the background check information released to my employer or prospective employer? (1) Children's administration will share with employers or approved care providers only that:

(a) You are disqualified; or

(b) You have not been disqualified by the background check.

(2) Division of developmental disabilities will release the source of the disqualifying crime or negative action and WSP rap sheet to authorized requesters as allowed by state law.

(3) The department will follow laws related to the release of criminal history records (chapters 10.97 and 43.43 RCW) and public disclosure (chapter 42.17 RCW) when releasing any information.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0250, filed 7/30/10, effective 8/30/10. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0250, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0525 When are individuals eligible for the one hundred twenty-day provisional hire? Individuals are eligible for the one hundred twenty-day provisional hire immediately. The signed background check application and fingerprinting process must be completed as required by the applicable DSHS program.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0525, filed 7/30/10, effective 8/30/10. Statutory Authority: Chapter 43.20A RCW, RCW 72.05.440 and 74.15.030. 01-15-019, § 388-06-0525, filed 7/10/01, effective 8/10/01.]

WAC 388-06-0700 What definitions apply to WAC 388-06-0710 through 388-06-0720? "Authorized entity" means a department of social and health services program, service provider, licensee, contractor, or other public or private agency that has permission from the department to conduct background checks through the background check central unit.

"Background check applicant" means an employee, volunteer, student, intern, licensee, service provider, contractor or other individual who is the subject of the background check and who will work in a position that:

(1) May have unsupervised access to vulnerable adults, juveniles or children as described in WAC 388-06-0610; or

(2) Is designated by the department as a sensitive position.

"Background check central unit" is the program responsible for conducting background checks for the department of social and health services.

(1) The background check central unit is responsible for:

(a) Compiling background check information from external and internal data sources; and

(b) Providing information to the authorized entity who requested the background check.

(2) The background check central unit does not:

(a) Make the final hiring, contracting, placement, or licensing decision for the department or authorized entity; or

(b) Determine what program, service provider, licensee, contractor, or other public or private agency qualifies as an authorized entity.

"Department" means the department of social and health services.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0700, filed 7/30/10, effective 8/30/10.]

WAC 388-06-0710 Who may submit a background check to the background check central unit? An authorized entity may request a background check through the background check central unit when the authorized entity has:

(1) A valid background check central unit account number;

(2) A current department background authorization form filled out and signed by the applicant; and

(3) Submitted the background check request under the applicable program requirements.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0710, filed 7/30/10, effective 8/30/10.]

WAC 388-06-0720 Who receives the results of a background check conducted by the background check central unit? (1) The background check central unit follows laws related to the release of criminal history records (chapter 10.97 and 43.43 RCW), public disclosure (chapter 42.56 RCW); and other applicable laws when releasing background information.

(2) The authorized entity who submits a background check request receives a copy of the background check results.

(3) The background check applicant may request a copy of his or her background check results.

(4) As required in RCW 74.39A.055(2), the department will share the results of state and national background checks with the Washington department of health to satisfy its certification responsibilities under chapter 18.88B RCW.

[Statutory Authority: RCW 43.43.832, 74.39A.055, 74.39A.050, 74.39A.095, 74.39A.260, 43.20A.710, and 43.43.837. 10-16-083, § 388-06-0720, filed 7/30/10, effective 8/30/10.]

Chapter 388-14A WAC
DIVISION OF CHILD SUPPORT RULES

WAC

388-14A-4500	What is the division of child support's license suspension program?
388-14A-4505	The notice of noncompliance and intent to suspend licenses.
388-14A-4510	Who is subject to the DCS license suspension program?
388-14A-4512	When may the division of child support certify a noncustodial parent for license suspension?
388-14A-4515	How do I avoid having my license suspended for failure to pay child support?
388-14A-4520	Signing a payment agreement may avoid certification for noncompliance.
388-14A-4525	How to obtain a release of certification for noncompliance.
388-14A-4527	How does a noncustodial parent request an administrative hearing regarding license suspension?
388-14A-4530	What can happen at an administrative hearing regarding license suspension?
388-14A-4535	Can the noncustodial parent file a late request for hearing if a license has already been suspended?
388-14A-4540	When is a DCS conference board available regarding license suspension issues?

WAC 388-14A-4500 What is the division of child support's license suspension program? (1) RCW 74.20A.320 and sections 2 through 4 of SSB 5166 (chapter 408, Laws of 2009) provide that, in some circumstances, the division of child support (DCS) may certify for license suspension a noncustodial parent (NCP) who is not in compliance with a child support order. These statutes call the NCP "the responsible parent."

(a) "Certify" means to notify the department of licensing or other state licensing entities that the NCP is not in compliance with a child support order and to ask them to take appropriate action against licenses held by the NCP. Before DCS can certify an NCP, DCS serves a notice on the NCP as described in WAC 388-14A-4505 and 388-14A-4510. This notice is called the notice of noncompliance and intent to suspend licenses, and is sometimes called the notice of noncompliance.

(b) "Responsible parent" is defined in 388-14A-1020. The responsible parent is also called the "noncustodial parent."

(2) "Noncompliance with a child support order" is defined in RCW 74.20A.020(18) and in WAC 388-14A-4510 (3).

(3) When DCS certifies the NCP, the department of licensing or other licensing entities take action to deny, suspend, or refuse to renew the NCP's license, according to the terms of RCW 74.20A.320(4) and section 3 of SSB 5166 (chapter 408, Laws of 2009).

(4) This section and sections WAC 388-14A-4505 through 388-14A-4530 cover the DCS license suspension program.

(5) DCS may certify an NCP who is not in compliance with a child support order to the department of licensing or any appropriate licensing entity. In determining which licensing entity receives the certification, DCS considers:

(a) The number and kind of licenses held by the parent; and

(b) The effect that suspension of a particular license will have in motivating the parent to pay support or to contact DCS to make appropriate arrangements for other relief.

(6) DCS may certify a parent to any licensing agency through which it believes the parent has obtained a license. DCS may certify a parent to as many licensing agencies as DCS feels necessary to accomplish the goals of the license suspension program.

(7) In certain circumstances spelled out in WAC 388-14A-4510 (2) and (3), DCS may serve the notice of noncompliance on a noncustodial parent but may stay the commencement of the objection period in WAC 388-14A-4505 (4)(b).

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4500, filed 1/12/10, effective 2/12/10. Statutory Authority: RCW 74.20A.320. 03-18-114, § 388-14A-4500, filed 9/2/03, effective 10/15/03. Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4500, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-510.]

WAC 388-14A-4505 The notice of noncompliance and intent to suspend licenses. (1) Before certifying a noncustodial parent (NCP) for noncompliance, the division of child support (DCS) must serve the NCP with a notice of noncompliance and intent to suspend licenses. This notice tells the NCP that DCS intends to submit the NCP's name to the department of licensing and any other appropriate licensing entity as a licensee who is not in compliance with a child support order.

(2) DCS must serve the notice by certified mail, return receipt requested. If DCS is unable to serve the notice by certified mail, DCS must serve the notice by personal service, as provided in RCW 4.28.080.

(3) The notice must include a copy of the NCP's child support order and must contain the address and phone number of the DCS office which issued the notice.

(4) The notice must contain the information required by RCW 74.20A.320(2), including:

(a) The address and telephone number of DCS office that issued the notice;

(b) That in order to prevent DCS from certifying the NCP's name to the department of licensing or other licensing entity, the NCP has twenty days from receipt of the notice, or sixty days after receipt if the notice was served outside the state of Washington, to contact the department and:

(i) Pay the overdue support amount in full;

(ii) Request a hearing as provided in WAC 388-14A-4527;

(iii) Agree to a payment schedule as provided in WAC 388-14A-4520; or

(iv) File an action to modify the child support order with the appropriate court or administrative forum, in which case DCS will stay the certification process up to six months.

(c) That failure to contact DCS within twenty days of receipt of the notice (or sixty days if the notice was served outside of the state of Washington) will result in certification of the NCP's name to the department of licensing and any other appropriate licensing entity for noncompliance with a child support order. Upon receipt of the notice:

(i) The licensing entity will suspend or not renew the NCP's license and the department of licensing (DOL) will suspend or not renew any driver's license that the NCP holds until the NCP provides DOL or the other licensing entity with a release from DCS stating that the NCP is in compliance with the child support order;

(ii) The department of fish and wildlife will suspend a fishing license, hunting license, occupational licenses (such as a commercial fishing license), or any other license issued under chapter 77.32 RCW that the NCP may possess. In addition, suspension of a license by the department of fish and wildlife may also affect the NCP's ability to obtain permits, such as special hunting permits, issued by the department. Notice from DOL that an NCP's driver's license has been suspended shall serve a notice of the suspension of a license issued under chapter 77.32 RCW.

(d) That suspension of a license will affect insurability if the NCP's insurance policy excludes coverage for acts occurring after the suspension of a license; and

(e) If the NCP subsequently comes into compliance with the child support order, DCS will promptly provide the NCP and the appropriate licensing entities with a release stating the NCP is in compliance with the order.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4505, filed 1/12/10, effective 2/12/10. Statutory Authority: RCW 74.20A.320. 03-18-114, § 388-14A-4505, filed 9/2/03, effective 10/15/03. Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-4505, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-520.]

WAC 388-14A-4510 Who is subject to the DCS license suspension program? (1) The division of child support (DCS) may serve a notice of noncompliance on a noncustodial parent (NCP) who is not in compliance with a child support order.

(a) DCS may serve a notice of noncompliance on an NCP who meets the criteria of this section, even if the NCP is in jail or prison. Unless the NCP has other resources available while in jail or prison, DCS stays the commencement of the objection period set out in WAC 388-14A-4505 (4)(b) until the NCP has been out of jail or prison for thirty days.

(b) DCS may serve a notice of noncompliance on an NCP who meets the criteria of this section, even if the NCP is a public assistance recipient. DCS stays the commencement of the objection period in WAC 388-14A-4505 (4)(b) until the thirty days after the NCP's cash assistance grant is terminated.

(2) Compliance with a child support order for the purposes of the license suspension program means the NCP owes no more than six months' worth of child support.

(3) Noncompliance with a child support order for the purposes of the license suspension program means an NCP has:

(a) An obligation to pay child support under a court or administrative order; and

(b) Accumulated a support debt, also called an arrears or arrearage, totaling more than six months' worth of child support payments; or

(c) Failed to do one of the following:

(i) Make payments required by a court order or administrative order towards a support debt in an amount that is more than six months' worth of payments; or

(ii) Make payments to the Washington state support registry under a written agreement with DCS toward current support and arrearages and the arrearages still amount to more than six months' worth of child support payments.

(4) There is no minimum dollar amount required for license suspension, as long as the arrears owed by the NCP amount to more than six months' worth of support payments:

Example 1. Assume the child support order sets current support at one hundred dollars per month: The NCP has not made a single payment since the order was entered seven months ago. This NCP is more than six months in arrears.

Example 2. Assume the child support order sets current support at one hundred dollars per month: The NCP has paid for the last few months, but owes arrears of over six hundred dollars. This NCP is more than six months in arrears.

Example 3. Assume the child support order sets current support at one hundred dollars per month: The child is over eighteen, and no more current support is owed. However, the NCP has a debt of over one thousand two hundred dollars. This NCP is more than six months in arrears.

Example 4. Assume a judgment of three thousand dollars is entered by the court: The order requires the NCP to pay fifty dollars per month toward the arrears. The NCP has not made payments toward this obligation for eight months. This NCP is more than six months in arrears.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4510, filed 1/12/10, effective 2/12/10. Statutory Authority: RCW 74.20A.320. 03-18-114, § 388-14A-4510, filed 9/2/03, effective 10/15/03. Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4510, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-530.]

WAC 388-14A-4512 When may the division of child support certify a noncustodial parent for license suspen-

sion? The division of child support (DCS) may certify a noncustodial parent (NCP) as being in noncompliance with a support order and may request the department of licensing (DOL) or any other licensing entity to suspend the NCP's license if:

(1) The NCP has failed to make a timely objection to a notice of noncompliance served under WAC 388-14A-4505. A timely objection must be filed within twenty days of receipt of the notice, or within sixty days of receipt if the notice was served outside of the state of Washington;

(2) The NCP has failed to file a motion with the appropriate court or administrative forum to modify the child support obligation within twenty days of service of the notice of noncompliance served under WAC 388-14A-4505 (or within sixty days if the notice was served outside of the state of Washington);

(3) The NCP has failed to comply with a payment agreement entered into under WAC 388-14A-4520;

(4) A hearing results in a final administrative order which determines that the NCP is not in compliance with a child support order and has not made a good faith effort to comply;

(5) The court enters a judgment on a petition for judicial review upholding an administrative order that determined that the NCP is not in compliance with a child support order and did not made a good faith effort to comply;

(6) The NCP has failed to comply with a payment schedule ordered by an administrative law judge (ALJ) under WAC 388-14A-4530; or

(7) The NCP failed to make satisfactory progress toward modification of the support order after a stay was granted under WAC 388-14A-4515(2).

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4512, filed 1/12/10, effective 2/12/10.]

WAC 388-14A-4515 How do I avoid having my license suspended for failure to pay child support? (1) After service of the notice of noncompliance, the division of child support (DCS) stays (delays) certification action if the noncustodial parent (NCP) takes one of the following actions within twenty days of service, or within sixty days of service if the notice was served outside of Washington:

(a) Contacts DCS and makes arrangements to pay the support debt in full;

(b) Requests an administrative hearing as provided in WAC 388-14A-4527;

(c) Provides proof that the NCP receives TANF, GAU, GAX or SSI;

(d) Provides proof that the NCP is currently incarcerated at a state or federal correctional facility;

(e) Provides proof that NCP has filed a proceeding to modify the support order; or

(f) Contacts DCS to negotiate and sign a written payment agreement as described in WAC 388-14A-4520.

(i) The stay for negotiation and obtaining signatures may last a maximum of thirty calendar days from the date the NCP contacts DCS; and

(ii) If no written payment agreement has been signed within thirty calendar days from the date the NCP contacted DCS, DCS schedules the matter for administrative hearing under WAC 388-14A-4530.

(2) If the NCP files a court or administrative action to modify the child support obligation, DCS stays the certification action.

(a) The stay for modification action may not exceed six months unless DCS finds good cause to extend the stay.

(b) The NCP must notify DCS that a modification proceeding is pending and must provide a copy of the motion or request for modification to DCS.

(3) A stay of certification does not require DCS to withdraw the notice of noncompliance.

(4) A stay of certification granted because the NCP is incarcerated, or because the NCP receives TANF, GAU, GAX or SSI is lifted thirty days after the justification no longer applies to the NCP.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4515, filed 1/12/10, effective 2/12/10. Statutory Authority: RCW 74.20A.320. 03-18-114, § 388-14A-4515, filed 9/2/03, effective 10/15/03. Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4515, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-540.]

WAC 388-14A-4520 Signing a payment agreement may avoid certification for noncompliance. (1) If a noncustodial parent (NCP) signs a payment agreement, the division of child support (DCS) stays the certification action.

(2) The signing of a payment agreement does not require DCS to withdraw the notice of noncompliance.

(3) By signing a payment agreement, the NCP waives the right to an administrative hearing on any notice of noncompliance served before the date the NCP signs the agreement.

(4) The payment agreement must state that if the NCP fails to make payments under the terms of the agreement and the NCP owes a debt of more than six months' worth of child support payments, DCS may resume certification action with no further notice to the NCP.

(5) In proposing or approving a payment agreement, DCS must take into account:

(a) The amount of the arrearages.

(b) The amount of the current support order.

(c) The earnings of the NCP.

(d) The needs of all children who rely on the NCP for support.

(e) Any documented factors which make the NCP eligible for a monthly arrears payment less than the amount suggested in the table in subsection (8) of this section, including but not limited to:

(i) Special needs children; or

(ii) Uninsured health care expenses.

(f) Any documented factors which make the NCP eligible for an arrears payment higher than the amount suggested in the table in subsection (8) of this section, including but not limited to the factors listed in RCW 26.19.075 for deviation from the standard calculation for child support obligations.

(g) If the NCP does not supply sufficient financial information and documentation to allow DCS to analyze and document the NCP's current financial situation and requirements, DCS may not be able to tailor a payment plan to the individual circumstances of the NCP.

(6) The payment agreement must require timely payments of current support and on the arrears, but may in appropriate circumstances:

(a) Provide for the payment of less than the current monthly support obligation for a reasonable time without requiring any payment on the arrears; and

(b) Provide for the payment of current support only for a reasonable time without requiring any payment on the arrears; and

(c) Require a reasonable payment schedule on the arrears once the NCP is paying the entire current monthly support obligation.

(7) The payment agreement may, in appropriate cases, require the NCP to engage in employment-enhancing activities to attain a satisfactory payment level. These employment-enhancing activities must be tailored to the individual circumstances of the NCP.

(8)(a) A reasonable monthly arrears payment is defined as a percentage of the NCP's "adjusted net income," which is the NCP's net monthly income minus any current support obligation. Documented factors as specified in subsection (4) of this section may be the basis for adjustments to the amounts on this table in order to develop a payment agreement which is tailored to the individual financial circumstances of the NCP.

(b) The following table sets forth the suggested monthly payments on arrears:

Monthly adjusted net income (ANI)	Monthly arrears payment = Percentage of ANI
$1,000 or less	2%
$1,001 to $1,200	3%
$1,201 to $1,500	4%
$1,501 to $1,900	5%
$1,901 to $2,400	6%
$2,401 to $3,000	7%
$3,001 or more	8%

(c) Examples of how to calculate the arrears payment are as follows:

(a) Monthly net income	=	$1,500
Current support	=	$300
Adjusted net income (ANI)	=	$1,200
Arrears payment = 3% of ANI	=	$36
(b) Monthly net income	=	$3,100
Current support	=	$-0-
Adjusted net income (ANI)	=	$3,100
Arrears payment = 8% of ANI	=	$248

(9) If the NCP and DCS are unable to agree to a payment plan, DCS schedules the matter for an administrative hearing.

(10) If the NCP fails to make payments under the terms of the agreement, DCS may resume certification action with no further notice to the NCP.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4520, filed 1/12/10, effective 2/12/10. Statutory Authority: RCW 74.20A.320. 03-18-114, § 388-14A-4520, filed 9/2/03, effective 10/15/03. Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4520, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-550.]

WAC 388-14A-4525 How to obtain a release of certification for noncompliance. (1) After the division of child support (DCS) has certified a noncustodial parent (NCP) to a licensing entity for noncompliance, the NCP may obtain a release from DCS if one of the following occurs:

(a) NCP pays the support debt in full, in which case DCS withdraws the notice of noncompliance;

(b) NCP enters into a payment agreement under WAC 388-14A-4520;

(c) DCS confirms that the NCP receives GAU, GAX, TANF or SSI;

(d) DCS confirms that the NCP is currently incarcerated at a state or federal correctional facility;

(e) The prosecuting attorney determines that the NCP is substantially complying with a contempt repayment agreement and recommends release;

(f) DCS receives any type of recurring payment, including but not limited to:

(i) Employer payments;

(ii) Unemployment compensation;

(iii) Labor and industries benefits;

(iv) Social security benefits;

(v) Retirement account garnishments;

(g) DCS believes that release of the certification for noncompliance will facilitate the NCP seeking employment, modification of the child support order(s), or compliance with the current order(s);

(h) DCS certified the NCP because the NCP failed to make a timely objection to the notice of noncompliance and:

(i) The NCP filed a late request for hearing; and

(ii) The final administrative order entered under WAC 388-14A-4530 contains a finding that the NCP made a good faith effort to comply with the order and establishes a payment schedule.

(2) If the NCP and DCS are unable to reach a payment agreement that would lead to release of the certification, the NCP may request a conference board under WAC 388-14A-6400.

(3) By signing a payment agreement with DCS, the NCP waives the administrative hearing right associated with any notice of noncompliance under WAC 388-14A-4505 which was served before the agreement was signed.

(4) DCS retains the right to reinstate the suspension action if the NCP meets the conditions of reinstatement but:

(a) Fails to follow through in a timely fashion with any verbal or written agreement made with DCS; or

(b) Fails to comply with the payment schedule contained in an administrative order entered under WAC 388-14A-4530.

(5) DCS may reinstate the suspension action at any time after releasing the certification, as long as the NCP's case still meets qualifications for certification.

(6) Unless the NCP pays the support debt in full, DCS is not required to withdraw the notice of noncompliance.

(7) DCS must provide a copy of the release to any licensing entity to which DCS has certified the NCP.

(8) The NCP must comply with any requirements of the licensing entity to get the license reinstated or reissued.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4525, filed 1/12/10, effective 2/12/10. Statutory Authority: RCW

74.20A.320. 03-18-114, § 388-14A-4525, filed 9/2/03, effective 10/15/03. Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4525, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-560.]

WAC 388-14A-4527 How does a noncustodial parent request an administrative hearing regarding license suspension? (1) After service of a notice of noncompliance and intent to suspend licenses under WAC 388-14A-4505, the noncustodial parent (NCP) may request an administrative hearing, also known as an adjudicative proceeding, under chapter 34.05 RCW.

(a) Any objection to the notice of noncompliance is considered to be a request for hearing, no matter how the objection is phrased.

(b) An objection that does not lead to the signing of a payment agreement under WAC 388-14A-4520 is considered to be a request for hearing on the notice.

(c) Even if the NCP specifically makes a request for hearing, the division of child support (DCS) always attempts to negotiate a payment agreement under WAC 388-14A-4520.

(2) A hearing request may be made in writing or orally, and may be made in person or by phone.

(3) A timely request for hearing must be received by DCS within twenty days of service of the notice of noncompliance, or within sixty days if the notice was served outside of the state of Washington.

(4) The effective date of a written request for hearing is the day the request is received by DCS. A written request for hearing must include:

(a) The NCP's current mailing address; and

(b) The NCP's daytime phone number, if available.

(5) The NCP may make an oral request for hearing under WAC 388-14A-6100:

(a) The request must contain sufficient information for DCS to identify the NCP, the DCS action objected to, and the case or cases involved in the hearing request.

(b) The effective date of an oral request for hearing is the date that the NCP makes a complete oral request for hearing, to any DCS representative in person or by leaving a message on the automated voice mail system of any DCS field office.

(6) If the NCP makes a timely request for hearing, DCS stays (delays) the certification process until a final administrative order is entered.

(7) If the NCP makes a late request for hearing after DCS has already certified the NCP to a licensing agency based on NCP's failure to make a timely objection to the notice of noncompliance and the licensing agency has suspended the NCP's license, DCS schedules the matter for hearing with the office of administrative hearings, as provided in WAC 388-14A-4535.

(8) If DCS certified the NCP to a licensing agency based on NCP's failure to comply with a payment agreement or a payment schedule established by a final administrative order, the NCP does not have any additional hearing right on the original notice of noncompliance.

(a) If the NCP previously signed a payment agreement, the NCP waived the administrative hearing right associated with any notice of noncompliance which was served before the agreement was signed.

(b) If the NCP failed to comply with a payment schedule established by a final administrative order, the NCP has already exercised the hearing right associated with the underlying notice of noncompliance.

(c) The NCP may attempt to negotiate a payment agreement with DCS, and may request a conference board if negotiations are not successful, as provided in subsections (2) and (3) of WAC 388-14A-4525.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4527, filed 1/12/10, effective 2/12/10.]

WAC 388-14A-4530 What can happen at an administrative hearing regarding license suspension? (1) An administrative hearing on a notice of noncompliance under WAC 388-14A-4505 is limited to the following issues:

(a) Whether the person named in the child support order is the noncustodial parent (NCP);

(b) Whether the NCP is required to pay child support under a child support order;

(c) Whether the NCP is more than six months in arrears; and

(d) Whether the NCP has made a good faith effort to comply with the order.

(2) When determining whether the NCP has made a good faith effort to comply with the order, the administrative law judge (ALJ) must consider whether the NCP:

(a) Kept DCS informed of any changes in address or employment;

(b) Provided employer information when employed so that DCS could institute income withholding;

(c) Paid at least one month's worth of current support by voluntary payment during a period when the NCP was not employed; or

(d) Can show any other relevant fact-based factors on which the ALJ may base a finding of good faith.

(3) If the ALJ finds that the NCP is not in compliance with the support order, but has made a good faith effort to comply, the ALJ must formulate a payment schedule after considering:

(a) The amount of the arrearages owed;

(b) The amount of the current support order;

(c) The earnings of the NCP; and

(d) The needs of all children who rely on the NCP for support.

(4) The ALJ must:

(a) Consider the individual financial circumstances of the NCP in evaluating the parent's ability to pay; and

(b) Establish a fair and reasonable payment schedule tailored to the NCP's individual circumstances.

(5) The payment schedule may:

(a) Include a graduated payment plan as described in WAC 388-14A-4520(8);

(b) Require the NCP to engage in employment-enhancing activities in order to attain a satisfactory payment level; and

(c) May be for the payment of less than current monthly support for a reasonable time.

(6) Unless the NCP shows an ability to pay immediately, the payment schedule is not required to include a lump sum payment for the amount of the arrears.

(7) The administrative order must contain a provision stating that:

(a) If the NCP does not comply with the payment schedule, DCS may proceed with the certification process with no further notice to the NCP;

(b) The payment schedule is for the limited purpose of avoiding license suspension; and

(c) DCS's authority to collect any and all amounts authorized under chapters 26.18, 26.23, 47.20 and 74.20A RCW is not affected by the payment schedule.

(8) The administrative law judge (ALJ) is not required to calculate the outstanding support debt beyond determining whether the NCP is at least six months in arrears. Any debt calculation shall not be binding on the department or the NCP beyond the determination that there is at least six months of arrears.

(9) If the NCP requests a hearing on the notice of noncompliance under the circumstances spelled out in WAC 388-14A-4510 (1)(a) or (b), DCS asks the office of administrative hearings to schedule a hearing. If the hearing results in a finding that the NCP is not in compliance with the order, or that DCS is authorized to certify the NCP, DCS stays the certification process until thirty days after the NCP:

(a) Is released from jail or prison; or

(b) Stops receiving cash public assistance.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4530, filed 1/12/10, effective 2/12/10. Statutory Authority: RCW 74.20A.320. 03-18-114, § 388-14A-4530, filed 9/2/03, effective 10/15/03. Statutory Authority: RCW 74.08.090, 74.20A.320. 01-03-089, § 388-14A-4530, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-570.]

WAC 388-14A-4535 Can the noncustodial parent file a late request for hearing if a license has already been suspended? (1) The noncustodial parent (NCP) may file a late request for hearing if the division of child support (DCS) has certified the noncustodial parent (NCP) because of the NCP's failure to object to the notice of noncompliance as provided in WAC 388-14A-4512(1), even if the department of licensing (DOL) or other licensing entity has suspended the NCP's license.

(2) When an NCP files a late request for hearing, DCS does not release the certification until:

(a) The NCP pays the support debt in full;

(b) DCS and the NCP sign a payment agreement under WAC 388-14A-4520;

(c) There is a final administrative order entered establishing a payment schedule because the NCP made a good faith effort to comply with the order; or

(d) There is a final administrative order entered determining that the NCP did not owe more than six months worth of support and that license suspension was not appropriate at the time of the certification.

(3) If the late request for hearing is filed within one year of the date the notice was served, DCS schedules the matter for administrative hearing under WAC 388-14A-4530.

(4) If the late request for hearing is filed more than one year after the date the notice was served, DCS schedules the matter for administrative hearing under WAC 388-14A-4530. At the hearing:

(a) The NCP must show good cause for the late request for hearing.

(b) The administrative law judge (ALJ) must find that the NCP has made a showing of good cause before granting relief in an administrative order.

(5) DCS and the NCP may negotiate and sign a payment agreement under WAC 388-14A-4520 at any time during this process.

(6) If DCS certified the NCP to a licensing agency based on NCP's failure to comply with a payment agreement or a payment schedule established by a final administrative order, the NCP does not have any additional hearing right on the original notice of noncompliance.

(a) If the NCP previously signed a payment agreement, the NCP waived the administrative hearing right associated with any notice of noncompliance which was served before the agreement was signed. See WAC 388-14A-4525(3).

(b) If the NCP failed to comply with a payment schedule established by a final administrative order, the NCP has already exercised the hearing right associated with the underlying notice of noncompliance.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4535, filed 1/12/10, effective 2/12/10.]

WAC 388-14A-4540 When is a DCS conference board available regarding license suspension issues? (1) A noncustodial parent (NCP) may request a conference board under WAC 388-14A-6400 to resolve any complaints and problems concerning a division of child support (DCS) case.

(2) If the NCP and DCS are not successful in negotiating a payment agreement to avoid license suspension or to get a license reinstated, NCP may request a conference board at any time.

(a) A conference board is not available to the NCP regarding negotiations that occur immediately after the service of a notice of noncompliance under WAC 388-14A-4505.

(b) During that time period, the NCP has a right to an administrative hearing on the notice, and if the NCP is not able to negotiate a payment agreement, the appropriate remedy is an administrative hearing under WAC 388-14A-4530.

[Statutory Authority: 2009 c 408, RCW 34.05.060, 43.20A.550, 74.04.055, 74.04.057, 74.20A.310, 74.20A.320(10), and 74.20A.350(14). 10-03-029, § 388-14A-4540, filed 1/12/10, effective 2/12/10.]

Chapter 388-61A WAC

SHELTERS FOR VICTIMS OF DOMESTIC VIOLENCE

(Formerly chapter 248-554 WAC)

WAC

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388-61A-0500 Are there requirements for drinking water?
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388-61A-0530 How must I ventilate the shelter?
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388-61A-0640 Will DSHS do an evaluation of the domestic violence agency?
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388-61A-0660 What will happen if there is a complaint to DSHS about the domestic violence agency?
388-61A-0670 Can DSHS waive any of the minimum standards of this chapter?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-61A-0005 What is the legal basis for the domestic violence shelter program? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0005, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0010 What is the purpose of having minimum standards for domestic violence shelters and services? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0010, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0015 Is DSHS required to provide funding to any domestic violence service that requests funding? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0015, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0020 What are the facility and service requirements for domestic violence services? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0020, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0025 What definitions apply to domestic violence shelters and services? [Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0025, filed 2/6/07, effective 3/9/07. Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0025, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0030 What safety requirements is the shelter required to meet? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0030, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0035 What are the general requirements for bedrooms? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0035, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0040 What kind of diaper changing area must I provide? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0040, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0045 What are the kitchen requirements? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0045, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0050 Are there any restrictions on food preparation? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0050, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0055 What are the requirements for providing food and clothing to shelter residents? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0055, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0060 What are the requirements for toilets, sinks, and bathing facilities? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0060, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0065 What types of linen do I need to provide to clients? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0065, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0070 What are the requirements for laundry facilities? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0070, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0075 Are there requirements for drinking water? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0075, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0080 What are the requirements for sewage and liquid wastes? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0080, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0085 What kind of heating system is required? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0085, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0090 How must I ventilate the shelter? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0090, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-

040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0095 How much lighting is required in the shelter? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0095, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0100 Are there any requirements about pets in the shelter? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0100, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0105 What first-aid supplies must I provide? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0105, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0110 What are the requirements for storing medications? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0110, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0115 What measures must I take for pest control? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0115, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0120 What are the requirements for labeling and storing chemicals and toxic materials? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0120, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0125 Where do I keep firearms and other dangerous weapons? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0125, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0130 What are the additional requirements for a safe home? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0130, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0135 What are the additional requirements for a shelter home? [Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0135, filed 2/6/07, effective 3/9/07. Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0135, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0140 What supportive services am I required to provide to clients? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0140, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0145 What is advocacy-based counseling? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0145, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0146 What information must the domestic violence service keep confidential? [Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0146, filed 2/6/07, effective 3/9/07.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0147 What information can be disclosed? [Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0147, filed 2/6/07, effective 3/9/07.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0148 What information needs to be included in a written waiver of confidentiality? [Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0148, filed 2/6/07, effective 3/9/07.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0149 What information must be provided to clients about their right to confidentiality? [Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0149, filed 2/6/07, effective 3/9/07.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0150 What type of training is required for staff of the domestic violence service? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0150, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0155 Must supervisors of domestic violence service staff have specific experience and training? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0155, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0160 What written policies and procedures do you need to have? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0160, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0165 Will DSHS do an evaluation of the domestic violence service? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0165, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0170 What will happen if I am out of compliance with my contract? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0170, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0175 What will happen if there is a complaint to DSHS about the domestic violence service? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0175, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

388-61A-0180 Can DSHS waive any of the minimum standards of this chapter? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0180, filed 3/16/01, effective 4/16/01.] Repealed by 10-22-040, filed 10/27/10, effective 11/27/10. Statutory Authority: Chapter 70.123 RCW.

WAC 388-61A-0200 What is the legal basis for the domestic violence shelter program? Chapter 70.123 RCW authorizes us to establish minimum standards for agencies that receive funding from the department of social and health services (DSHS) to provide domestic violence shelter and supportive services.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0200, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0210 What is the purpose of having minimum standards for domestic violence shelters and supportive services? The purpose of these rules is to have uniform statewide standards for domestic violence shelters and supportive services funded by DSHS. Minimum standards are necessary to provide rules for agencies that contract with us to provide shelter and supportive services for domestic violence victims. These standards address issues such as food, clothing, emergency housing, safety, security, and advocacy.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0210, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0220 What definitions apply to this chapter? "Advocacy" means that the client is involved with an advocate in individual or group sessions with a primary

focus of safety planning, empowerment, and education of the client through reinforcement of the client's autonomy and self-determination. Advocacy also means speaking and acting for change or justice with, or on behalf of, another person or cause. Advocacy is survivor-centered and uses nonvictim blaming methods that include:

• Identifying barriers to, and strategies to enhance, safety, including safety planning.

• Clarifying and increasing awareness of the power and control associated with domestic violence and the options one may have to obtain resources while staying safe.

• Supporting independent decision-making based on the unique needs and circumstances of each individual.

"Advocate" means a trained staff person who works in a domestic violence agency and provides advocacy to clients.

"Child care" means the temporary care of a client's child or children by staff of the domestic violence agency at the agency's location or another location where the client is receiving confidential or individual services from the domestic violence agency or is participating in activities sponsored by the domestic violence agency, other than employment, and so long as the client remains on the premises.

"Children/youth activities" means activities other than children/youth advocacy, such as recreational and educational activities, and including child care as defined in this chapter.

"Children/youth advocacy" means an age-appropriate intervention service that strives to assist children/youth to express feelings about their exposure to domestic violence. It is an educational, rather than a therapeutic intervention, and is focused on providing education about domestic violence, safety planning, and developing or enhancing problem-solving skills. Advocacy can be provided on an individual basis and in group settings.

"Client" means a victim of domestic violence who is accessing services at a domestic violence agency. Client can also be referred to as a survivor, service recipient, or resident.

"Cohabitant" means a person who is or was married, in a state registered domestic partnership, or cohabiting with another person in an intimate or dating relationship at the present time or at some time in the past. Any person who has one or more children in common with another person, regardless of whether they have been married, were/are in a domestic partnership with each other, or have lived together at any time, must be treated as a cohabitant. Any person who is or was in a dating relationship with another person at the present or at some time in the past, regardless of whether they lived together at any time, must be treated as a cohabitant.

"Community education" refers to information that is provided in community settings about domestic violence and services related to victims of domestic violence. Community education activities include: Training, presentations, outreach to specific communities or geographic areas, community events, and media events.

"Confidential communication" means all information, oral, written or nonverbal, that is transmitted between a victim of domestic violence and an employee or supervised volunteer of a domestic violence agency in the course of their relationship and in confidence by means which, so far as the victim is aware, does not disclose the information to a third person.

"Confidential information" includes, but is not limited to, any information, advice, notes, reports, statistical data, memoranda, working papers, records or the like, made or given during the relationship between a victim of domestic violence and a domestic violence agency, however maintained. Confidential information includes the name, address, telephone number, social security number, date of birth, nine-digit postal (ZIP) code, physical appearance of, case file or history of, and other information that would personally identify a victim of domestic violence who seeks or has received services from a domestic violence agency.

"Crisis hotline or helpline" means a designated telephone line of the domestic violence agency that operates twenty-four hours a day, three hundred sixty-five days a year. A hotline/helpline provides crisis intervention, safety planning, information, and referral services.

"Crisis intervention" means services provided to an individual in crisis to stabilize an individual's emotions, clarify issues, and provide support and assistance to help explore options for resolution of the individual's immediate crisis and needs.

"Department" means the department of social and health services (DSHS).

"Domestic violence" is a pattern of assaultive and coercive behaviors that an adult or adolescent uses to maintain power and control over their intimate partner. Abusive tactics may include, but are not limited to the following: Physical abuse, sexual abuse, intimidating tactics, physical and/or psychological isolation of the victim, repeated attacks against the victim's competence, alternating use of indulgences, control of family funds and resources, stalking, and the use of children and systems to control the victim. The abuser's use of physical force against persons or property or the use of conduct that establishes credible threat of physical harm (i.e. terrorizing tactics) combined with other controlling tactics are key elements of domestic violence. The effect of the overall pattern of assaultive and coercive behavior is to increase the abuser's power and control in the relationship. It includes, but is not limited to, the categorization of offenses defined in RCW 10.99.020(3) when committed by one cohabitant against another.

"Domestic violence agency" means an agency that provides shelter and advocacy for domestic violence clients in a safe and supportive environment.

"Intimate partner violence" focuses on the most common form of domestic violence, which is between adult or adolescent intimate partners or cohabitants, rather than on violence between nonintimate adult or adolescent household members.

"Legal advocacy" means personal support and assistance with victims of domestic violence to ensure their interests are represented and their rights upheld within the civil and criminal justice systems, including administrative hearings. It includes educating and assisting victims in navigating the justice systems; assisting victims in evaluating advantages and disadvantages of participating in the legal processes; facilitating victims' access and participation in the legal systems; and promoting victims' choices and rights to individuals within the legal systems.

"Lodging unit" means one or more rooms used for a victim of domestic violence including rooms used for sleeping or sitting.

"Marginalized populations" includes, but is not limited to, populations that have been historically underserved and oppressed in society because of ethnicity, race, culture or language diversity, age, sexual orientation, or disability.

"Personally identifying information" includes, but is not limited to, first and last name, home or other physical address, telephone number, Social Security number, date of birth, nine-digit postal (ZIP) code, physical appearance of, case file or history of, and other information that would personally identify a victim of domestic violence who seeks or has received services from a domestic violence agency, or such other information which, taken individually or together with other identifying information, could identify a particular individual.

"Program" means the DSHS domestic violence program.

"Resident" means a client of the domestic violence agency who is residing in a shelter as defined in this chapter.

"Safe home" means a shelter that has two or fewer lodging units and has a written working agreement with a domestic violence agency.

"Safety plan" is a process of thinking through with the victim how to increase safety for both the victim of domestic violence and any dependent children of the victim. Safety planning addresses both immediate and long term risks, barriers, or concerns regarding the victim and any dependent children. It is based on knowledge about the specific pattern of the domestic violence perpetrator's tactics and the protective factors of the victim and any dependent children. Safety planning can be done formally, informally, in writing or orally, or in any other conversational process between the victim and advocate.

"Secretary" means the DSHS secretary or the secretary's designee.

"Shelter" means a safe home or shelter home that provides temporary refuge and food and clothing offered on a twenty-four hour, seven-day-per-week basis to victims of domestic violence and their dependent children. Domestic violence agencies may use hotels and motels for victims who need safe shelter, but the domestic violence agency must also have a shelter home and/or safe home(s) that meet the requirements of this chapter.

"Shelter home" means a shelter that has three or more lodging units and is either a component of, or has a written working agreement with, a domestic violence agency.

"Staff" means persons who are paid or who volunteer to provide services to clients and are a part of a domestic violence agency.

"Support group" means interactive group sessions of two or more victims of domestic violence that is facilitated by trained staff on a regular basis. Participants share experiences, offer mutual support, and receive information and education around a specific topic of common interest. Support groups validate the experiences of victims, explore options, build on strengths, and respect participants' rights to make their own decisions. A shelter or house meeting where, for example, chores are discussed, and there is no advocacy provided, is not a support group.

"Victim" means a cohabitant who has been subjected to domestic violence.

"We, us and our" refers to the department of social and health services and its employees.

"You, I and your" refers to the domestic violence agency.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0220, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0230 What service model must be used to provide the services required by these rules? Shelters and supportive services for victims of domestic violence are essential to provide protection to victims from further abuse and physical harm. Research demonstrates that access to supportive services that increase a survivor's knowledge of safety planning and awareness of community resources leads to increased safety and well being over time. Consequently, the model for providing services must incorporate the following practices:

(1) Services provided to victims must include access to safety, advocacy, information about options, and referrals to helping resources.

(2) Services that blame the victim for the abuse and do not hold the abuser accountable for the violence, are ineffective and will likely result in further harm to the victim, up to and including death. Therefore, minimum standards for the services and practices governed by these rules must use an empowerment model that:

(a) Promotes safety for all victims of intimate partner violence and their dependent children.

(b) Are survivor-centered and treat victims with dignity and respect.

(c) Builds on the strengths and resources of individuals and families, respecting their autonomy and self-determination.

(d) Supports the relationship between victims and their dependent children.

(e) Offers options and support for autonomous decision-making that is based on the needs and circumstances of each victim and their family.

(f) Assists individuals and families in accessing protection and services that are respectful and inclusive of cultural and community characteristics.

(g) Ensures agency accountability by involving victims in evaluating the services they receive from the domestic violence agency.

(h) Supports and engages in collaboration with other community agencies and systems for the purpose of developing a comprehensive response system for victims and their dependent children.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0230, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0240 Is DSHS required to provide funding to any domestic violence agency that requests funding? (1) We are not obligated to disburse funds to all domestic violence agencies that comply with the minimum standards set forth in this chapter. The goal of this program is to provide funding and support for the statewide development, stability, and expansion of emergency shelter and supportive services for victims of domestic violence. Funding for

this program is intended to be used to develop and maintain domestic violence agencies statewide that are:

(a) Focused on victim advocacy, safety, empowerment, maintaining confidentiality, and safety planning.

(b) Inclusive and responsive to the ethnic, cultural, racial and socioeconomic diversity of the state.

(c) Flexible and designed to meet the needs of domestic violence victims at the local level.

(2) In support of the program goal, if an agency applies to receive funding we will consider such things as:

(a) Geographic location.

(b) Population ratios.

(c) Population need for services.

(d) An agency's experience in providing domestic violence services and its ability to provide services that comply with these minimum standards.

(e) The availability of other domestic violence agencies in a community and the level of collaboration between and among existing agencies.

(f) The amount of funding we have available to maintain stability and support for existing domestic violence agencies funded by DSHS.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0240, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0250 What are the requirements for domestic violence agencies? In order for us to contract with an agency for domestic violence services, the agency must provide emergency shelter and supportive services to victims of domestic violence. The agency must comply with the:

(1) Supportive service and administrative standards for domestic violence agencies; and

(2) General facility standards for shelter homes and safe homes; and

(3) Additional standards for shelter homes; or

(4) Additional standards for safe homes.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0250, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0260 What supportive services must a domestic violence agency provide? (1) Domestic violence agencies must utilize a survivor-centered and empowerment service model as described in this chapter. Such a model:

(a) Promotes safety for all victims and their dependent children.

(b) Builds on the strengths and resources of individuals and families, respecting their autonomy and self-determination.

(c) Supports the relationship between victims and their dependent children.

(d) Offers options and support for autonomous decision making based on the needs and circumstances of each victim and their family.

(e) Assists individuals and families in accessing protection and services that are respectful of cultural and community characteristics.

(f) Ensures agency accountability by involving victims in evaluating the services they receive from the domestic violence agency.

(2) The manner in which supportive services are provided by the domestic violence agency must be in alignment with the empowerment service model described in this chapter, and must also:

(a) Include a discussion of safety and options with each victim of domestic violence seeking assistance.

(b) Be respectful and respond to each client's life situation, and respect each person's right to self-determination.

(c) Be provided in a safe and supportive environment that offers the client the opportunity to examine the events that led to the need for domestic violence services.

(d) Be provided in a private setting for the comfort of the client and to protect confidentiality of conversations.

(3) Domestic violence agencies that contract with us must provide the following supportive services:

(a) Crisis hotline or helpline.

(b) Crisis intervention.

(c) Safety planning.

(d) Emergency domestic violence shelter.

(e) A day program or drop-in service for victims who have found other shelter but who have a need for supportive services.

(f) Individual advocacy including legal advocacy.

(g) Support groups.

(h) Child care assistance during individual advocacy sessions and support groups for the adult victim.

(i) Supportive services and resources for children/youth residing in emergency domestic violence shelter.

(j) Transportation assistance or access to transportation.

(k) Information and referral.

(l) Community education activities.

(4) For clients residing in emergency domestic violence shelter you:

(a) Must provide clients with access to a trained staff person twenty-four hours a day, three hundred sixty-five days a year.

(b) Must give clients the opportunity to receive and participate in supportive services during their stay in shelter.

(c) Cannot require that clients participate in supportive services as a condition of residing in the shelter.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0260, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0270 What services and resources must be available to children/youth residing in emergency domestic violence shelter? (1) With the permission of a parent/guardian, children/youth must be offered the opportunity to receive and participate in the following age-appropriate supportive services during their shelter residency:

(a) Orientation to the shelter.

(b) Information about domestic violence.

(c) Individual and/or group advocacy and support.

(d) Information and referral to other supportive services.

(2) The domestic violence agency must provide a safe and secure play area for children/youth residing in the emergency domestic violence shelter.

(3) The domestic violence agency must provide information to the client about resources for indoor and outdoor recreational activities in the community for children/youth residing in emergency shelter, such as outings to parks, playgrounds, movies, libraries, sports activities, youth clubs and other similar activities.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0270, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0280 What are the requirements for the crisis hotline or helpline? (1) You must provide a crisis hotline/helpline telephone number to access services of the domestic violence agency. The telephone number must be listed in the local telephone book, and identified as the crisis hotline/helpline telephone number of the domestic violence agency. The crisis hotline/helpline telephone number must also be widely distributed throughout the service area covered by the domestic violence agency.

(2) The crisis hotline/helpline service must comply with the following minimum requirements:

(a) It must operate twenty-four hours a day, three hundred sixty-five days a year.

(b) It must be a dedicated telephone line that serves as the crisis hotline or helpline.

(c) Staff that answer the hotline/helpline must be trained in, and familiar with, all referral and intake practices of the domestic violence agency.

(d) In most cases, callers to the hotline/helpline must be able to speak, within fifteen minutes, to a trained staff person from whom the caller can obtain services, including access to emergency shelter.

(e) Staff must have access to TTY or similar technology, and they must be trained on its use.

(f) Safety must be addressed in every call.

(3) You must have written procedures that address the following:

(a) How crisis hotline staff will meet the needs of non-English speaking and hearing impaired callers.

(b) Steps that must be taken when a caller requests emergency shelter.

(c) If you use an answering service, or any other similar system, how you will provide training to the staff of the answering service, and how you will monitor the services provided to your agency.

(4) If you use a call-forwarding system for your domestic violence agency's hotline/helpline, answering service, or any other similar system, you must guarantee that the caller's first contact is supportive.

(5) You may use an answering machine, voice mail, or similar recording device as a back-up means of responding to calls to your agency's crisis hotline/helpline. However, these devices cannot be used as your agency's primary method of answering crisis hotline/helpline calls. Messages left on your agency's answering machine, voice mail, or similar recording device must be returned within the time frame described in subsection (2)(d) of this section.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0280, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0290 What are the requirements for accessing emergency domestic violence shelter? Domestic violence agencies must meet the following requirements in providing emergency domestic violence shelter:

(1) Your agency must have written procedures regarding your shelter intake process.

(2) You must have a staff person available twenty-four hours a day, three hundred sixty-five days a year, who is able to assess requests for emergency domestic violence shelter and arrange for immediate intake into your shelter or a hotel/motel.

(3) Where an individual is eligible for emergency domestic violence shelter:

(a) A staff person must be present to admit a service recipient into the shelter home.

(b) Reasonable efforts must be made by the domestic violence agency to have a staff person present to admit a service recipient into a safe home or hotel/motel.

(4) Referrals to other services or domestic violence agencies must be provided to an individual when:

(a) Your shelter home or safe home(s) are full.

(b) A client residing in shelter must be transferred to another domestic violence agency for reasons of safety of the client.

(c) The person seeking shelter is ineligible for your services.

(d) An inappropriate referral was made to your domestic violence agency.

(e) The person seeking shelter has problems that require services of another agency or agencies before receiving domestic violence services.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0290, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0300 What information must be in a client's file? (1) You must have a written file for clients who are served by your domestic violence agency. Client files must:

(a) Include an intake that clearly documents each client's eligibility for domestic violence services.

(b) Be brief in documenting the services provided to the client.

(c) Document only sufficient information to identify the service provided, and must not include any references to service recipient feelings, emotional or psychological assessments, diagnoses, or similar subjective observations or judgments. Documentation must not include any direct quotes from the client.

(d) Include copies of all required releases and client notices.

(2) Where supportive services are provided to child/youth of clients, the domestic violence agency must:

(a) Maintain separate documentation for each child/youth that receives supportive services. Written documentation must not be included in the file of the parent/guardian.

(b) Be brief in documenting the supportive services provided to the child/youth.

(c) Document only sufficient information to identify the service provided, and must not include any references to the child/youth's feelings, emotional or psychological assessments, diagnoses, or similar subjective observations or judgments. Documentation must not include any direct quotes from the child/youth.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0300, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0310 What information must the domestic violence agency keep confidential? (1) Agents, employees, and volunteers of a domestic violence agency

must maintain the confidentiality of all personally identifying information, confidential communications, and all confidential information as defined in this chapter. Information that individually or together with other information could identify a particular victim of domestic violence must also be kept confidential.

(2) Any reports, records, working papers, or other documentation, including electronic files that are maintained by the domestic violence agency and information provided to the domestic violence agency on behalf of the client, must be kept confidential. Any information considered privileged by statute, rule, regulation or policy that is shared with the domestic violence agency on behalf of the client must not be divulged without a valid written waiver of the privilege that is based on informed consent, or as otherwise required by law.

(3) You must comply with the provisions of this section regarding confidential communications concerning clients regardless of when the client received the services of the domestic violence agency.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0310, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0320 What information can be disclosed? (1) You can disclose confidential information only when:

(a) The client provides informed, written consent to the waiver of confidentiality that relates only to the client or the client's dependent children.

(b) Failure to disclose is likely to result in a clear, imminent risk of serious physical injury or death of the client or other person.

(c) Disclosure is required under chapter 26.44 RCW, Abuse of children.

(d) Release of information is otherwise required by law or court order, or following in-camera review pursuant to RCW 70.123.075, with the following additional requirements:

(i) The domestic violence agency must make reasonable attempts to provide notice to the person affected by the disclosure of the information.

(ii) If personally identifying information is or will be disclosed, the domestic violence agency must take steps necessary to protect the privacy and safety of the persons affected by the disclosure of information.

(2) Any release of information subject to any of the exceptions set forth above must be limited to the minimum necessary to meet the requirement of the exception, and such release does not void the client's right to confidentiality and privilege on any other confidential communication between the client and the domestic violence agency.

(3) In the case of an unemancipated minor, the minor and the parent or guardian must provide the written consent. Consent for release may not be given by a parent who has abused the minor or the minor's other parent. In the case of a disabled adult who has been appointed a guardian, the guardian must consent to release unless the guardian is the abuser of the disabled adult.

(4) To comply with federal, state, tribal, or territorial reporting, evaluation, or data collection requirements, a domestic violence agency may disclose aggregated nonpersonally identifying data about services provided to their clients and nonpersonally identifying demographic information.

(5) A copy of the disclosed information must be provided to the client, if requested by the client.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0320, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0330 What information must be included in a written waiver of confidentiality? (1) To be valid, a written waiver of confidentiality must:

(a) Be voluntary.

(b) Relate only to the client or the client's dependent children.

(c) Clearly describe the scope and any limitations of the information to be released.

(d) Include an expiration date for the release.

(e) Inform the client that consent can be withdrawn at any time whether it is made orally or in writing.

(2) If the written waiver of confidentiality does not include an expiration date, it must expire ninety days after the date it was signed.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0330, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0340 What information must be provided to clients about their right to confidentiality? (1) You must provide each client with a written "notice of rights" at the time of initial and any subsequent intake into the domestic violence agency. At a minimum, the notice of rights must inform clients of the following:

(a) The client's right to privacy and confidentiality of the information shared with the domestic violence agency.

(b) Exceptions to confidentiality as described in this chapter.

(c) That if the client signs a written waiver of confidentiality that allows their information to be shared with others, the client does not give up their right to have that information protected under other statutes, rules or laws.

(d) That the client has the right to withdraw a written waiver of confidentiality at any time.

(e) That the domestic violence agency will not condition the provision of services to the client based on a requirement that the client sign one or more releases of confidential information.

(2) Information on the "notice of rights" must be explained to the client at the time of intake into the domestic violence agency and then again, at the time the client is considering whether to sign a written waiver of confidentiality.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0340, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0350 What type of training is required for staff of the domestic violence agency? Initial and continuing education training of domestic violence agency staff is critically important. Advocates and advocate supervisors must be able to demonstrate an understanding of the nature and scope of domestic violence as defined by this chapter, as well as the historical and societal attitudes in which domestic violence is rooted. Training must be current and relevant to the provision of empowerment-based advo-

cacy. In furtherance of these goals, domestic violence agency staff must meet the following minimum training requirements.

Initial training for staff providing supportive services and staff supervisors

(1) A minimum of twenty hours of initial basic training that covers the following topics and skills:

(a) Theory and implementation of empowerment-based advocacy.

(b) The history of domestic violence.

(c) Active listening skills.

(d) Legal, medical, social service and systems advocacy.

(e) Confidentiality and ethics.

(f) Safety planning skills and barriers to safety.

(g) Planning, clarifying issues and options, and crisis intervention.

(h) Providing services and advocacy to individuals from marginalized populations.

(i) Policies and procedures of the domestic violence agency.

Continuing education training for staff providing supportive services and staff supervisors

(2) Based on their date of hire with the domestic violence agency, staff providing supportive services and staff supervisors must obtain an annual minimum of thirty hours of continuing education training beginning in their second year with the domestic violence agency, and in every year thereafter. Continuing education training must include:

(a) A minimum of fifteen hours of training on advocacy that is directly related to serving victims of domestic violence and their children.

(b) A minimum of five hours of training on providing services and advocacy to individuals from marginalized populations.

(3) Not more than ten hours of the thirty hours of continuing education training can be obtained from video, audio, or similar self-study methods.

Training for staff not providing supportive services

(4) Domestic violence agency staff who do not provide supportive services to clients or their dependent children are not required to obtain initial and continuing education training as described in this section. Examples of staff that are included in this category are shelter housekeeping staff, individuals providing child care assistance as defined in this chapter, and bookkeeping and accounting staff. It is recommended, however, that staff who may come into contact with clients of the domestic violence agency and their dependent children, but who do not provide supportive services, receive training on the following:

(a) Confidentiality.

(b) Relevant policies and procedures of the domestic violence agency.

(c) Mandated reporting of child abuse/neglect as required by chapter 26.44 RCW, Abuse of children.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0350, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0360 How should training be documented? Initial and continuing education training received by staff and supervisors of staff providing supportive services must be recorded in a training log. At a minimum the log must include:

(1) Date(s) of training.

(2) Title or subject matter of the training.

(3) Individual or organization that provided the training.

(4) Number of training hours received.

(5) Training method (e.g. in-person, video, audio, self-study, or other method).

(6) For continuing education training, whether the training was on advocacy or serving individuals from marginalized populations.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0360, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0370 Must supervisors of domestic violence agency staff have specific experience and training? Supervisors of staff providing supportive services to domestic violence clients must have the following minimum experience and training requirements prior to being hired as a supervisor.

(1) At least two years of experience providing advocacy to victims of domestic violence within a domestic violence agency.

(2) A minimum of fifty hours of training on domestic violence issues and advocacy within three years prior to being hired as a supervisor.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0370, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0380 What written policies or procedures do you need to have? The domestic violence agency must have written policies or procedures that cover the following issues:

(1) Procedures for the emergency shelter intake process, including that victims in immediate danger or immediate risk of harm will receive first priority for shelter.

(2) Confidentiality and protection of client records and communication.

(3) Nondiscrimination relating to staff, clients, and provision of services.

(4) The provision of bilingual and interpreter services to clients.

(5) Procedures for responding to calls on the crisis hotline/helpline from non-English speaking and hearing impaired callers.

(6) If you use an answering service, or any other similar system to answer your crisis hotline/helpline calls, procedures for providing training to the staff of the answering service, and how you will monitor the services provided to your agency.

(7) Procedures for responding to subpoenas and warrants.

(8) Reporting of child abuse as legally mandated.

(9) Client access to their files.

(10) Grievance procedure for clients.

(11) Emergency procedures for fire, disaster, first aid, medical and police intervention.

(12) Procedures and periods for records retention.

(13) Accounting procedures.

(14) Personnel policies and procedures that include the following:

(a) Recruitment for staff and volunteers - agencies must recruit, to the extent feasible, persons who are former victims of domestic violence to work as paid or volunteer staff.

(b) Hiring.

(c) Promotion and termination of staff.

(d) Performance evaluation.

(e) Grievance procedure for staff.

(f) Maintenance of personnel and training files, to include job descriptions for paid staff and volunteers.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0380, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0390 What safety requirements are shelters required to meet? You must keep your equipment and the physical structures in the shelter, including furniture and appliances, safe and clean for the clients you serve. You must:

(1) Maintain the shelter, premises, equipment, and supplies in a clean, safe and sanitary condition, free of hazards, and in good repair.

(2) Provide guard or handrails, as necessary, for stairways, porches and balconies.

(3) Maintain swimming pools, wading pools, bathtubs, hot tubs, spas, and bathing beaches in a safe manner and in such a way that does not present a health hazard, safety problem, or nuisance.

(4) Have a method for securing all windows, doors, and other building accesses to prevent the entry of intruders.

(5) Make sure all window screens can be secured to prevent children from falling from window openings.

(6) Make sure that clients residing in shelter are able to immediately enter the shelter if they do not have the ability to independently access the facility with their own key, keycard, door code, or other device.

(7) Provide adequate lighting of exterior areas to ensure the safety of clients residing in shelter and staff during the night.

(8) Provide a way for staff to enter any area occupied by clients should there be an emergency.

(9) Secure all unused refrigerators and freezers accessible to children in such a way that prevents them from climbing in and becoming trapped.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0390, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0400 What are the requirements for bedrooms? You must provide a bed in good condition, with a clean and comfortable mattress.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0400, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0410 What are requirements for cribs or bassinets? If the shelter provides cribs or bassinets, the shelter must comply with each of these requirements:

(1) Cribs and bassinets must have a clean, firm mattress covered with waterproof material that is easily sanitized.

(2) Crib mattresses must fit snugly to prevent the infant from being caught between the mattress and crib side rails.

(3) Cribs must be assembled correctly, and not have any missing, loose, or broken hardware or slats. There must not be any missing, loose, broken or improperly installed screws, brackets or other hardware on the crib or mattress support.

(4) Soft objects and loose bedding, including bumper pads, cannot be used in cribs and bassinets.

(5) Cribs must be made of wood, metal, or approved plastic with secure latching devices.

(6) Cribs must have no more than two and three-eighths inches of space between vertical slats so an infant's body cannot fit through the slats. There must not be any missing or cracked slats.

(7) Cribs must not have corner posts over one-sixteenth inch high so a child's clothing cannot catch.

(8) Crib headboards and footboards must not have any cutouts that would result in a child's head getting trapped.

(9) For mesh-sided cribs and playpens:

(a) Mesh must not have any tears, holes or loose threads.

(b) Mesh must be securely attached to the top rail and floor plate.

(c) Top rail covers must not have any tears or holes.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0410, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0420 What kind of diaper changing area must I provide? You must provide a sanitary diaper changing area. In addition, you must develop and post in view of the changing area, hygienic procedures for handling and storing diapers and sanitizing the changing area.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0420, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0430 What are kitchen requirements? The following are the minimum general requirements for kitchen facilities:

(1) A sink for washing dishes.

(2) A refrigerator or other storage equipment capable of maintaining a consistent temperature of forty-five degrees Fahrenheit or lower.

(3) A range or stove.

(4) Covered garbage container.

(5) Eating and cooking utensils that are clean and in good repair.

(6) Counter surfaces that are clean and resistant to moisture.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0430, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0440 What are the requirements for providing food to clients residing in shelter? (1) Your domestic violence agency must provide food and beverages for the basic sustenance of clients residing in shelter, unless other resources are immediately available.

(2) You must store food and beverages, including infant formula, at the shelter to provide to clients residing in shelter when other resources are not immediately available, and for shelter residents who are unable to safely access other food resources.

(3) Milk and infant formula must be available at all times for children residing in the shelter.

(4) You must purchase and provide only food and beverages that are of safe quality to clients residing in shelter.

Storage, preparation, and serving techniques must ensure that nutrients are retained and spoilage is prevented.

(5) Food and beverages prepared for clients residing in shelter must be prepared, served and stored safely and in a sanitary manner.

(6) Food must be available to prepare school lunches, if lunch is not otherwise available to the children of shelter residents.

(7) Clients residing in shelter must be provided, or have immediate access to, food that is in accordance with their religious or cultural beliefs and personal practices.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0440, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0450 What are the requirements for providing clothing to clients residing in shelter? (1) If an adult or child comes into shelter without adequate clothing, you must assist them with accessing clean, well-fitting clothing appropriate to the season, and the individual's age, gender and particular needs.

(2) Clothing that you provide must be clean and have been stored in a sanitary manner.

(3) Clothing that is provided to an individual becomes that person's personal property and must not be shared or retrieved from the client when they leave the shelter.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0450, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0460 What personal hygiene items do I need to provide to clients residing in shelter? All clients residing in shelter must be provided with personal hygiene products during their residency, such as soap, hair care products, toothbrush and paste, and deodorant. Particular attention must be paid to providing items for individuals that have special needs because of their ethnicity, disability, or medical condition.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0460, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0470 What are the requirements for toilets, sinks, and bathing facilities? You must meet these requirements for toilets, sinks, and bathing facilities.

(1) You must provide at least one indoor flush-type toilet, one nearby sink for hand washing, and a bathtub or shower facility. These facilities must be located within the shelter building premises.

(2) You must comply with all of the following requirements for toilet and bathing facilities:

(a) Toilet and bathing facilities must allow for privacy of shelter residents.

(b) Toilets, urinals, and hand washing sinks must be the appropriate height for the children served, or have a safe and easily cleaned step stool or platform that is water resistant.

(c) Facilities for hand washing and bathing must be provided with hot and cold running water. Hot water must not exceed one hundred and twenty degrees Fahrenheit.

(d) Potty chairs and toilet training equipment for toddlers must be regularly maintained, disinfected, and kept in a sanitary condition. When in use, you must put potty chairs on washable, water resistant surfaces.

(e) You must provide soap and clean washcloths and towels, disposable towels or other hand-drying devices to shelter residents.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0470, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0480 What types of linen do I need to provide to clients? (1) You must provide the following to clients residing in shelter:

(a) Bed linen, towels and washcloths that are clean and in good repair. After use by a client, bed linen, towels and washcloths must be laundered prior to use by another client.

(b) A clean liner for a sleeping bag unless the bag is cleaned between uses by different clients.

(2) Clients residing in shelter must be provided with changes of clean bed linen, towels and washcloths upon their request.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0480, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0490 What are the requirements for laundry facilities? The requirements for laundry facilities at your shelter include the following:

(1) You must provide adequate laundry and drying equipment, or make other arrangements for getting laundry done on a regular basis. Laundry facilities in the shelter must be provided free to shelter residents.

(2) You must handle and store laundry in a sanitary manner.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0490, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0500 Are there requirements for drinking water? Water supplies that are used for human consumption must be from a water system that has been approved by the local health authority or department as safe for human consumption. This refers to both public water systems and individual systems.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0500, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0510 What are the requirements for sewage and liquid wastes? You must discharge sewage and liquid wastes into a public sewer system or septic system that has been approved by the local health authority or department.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0510, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0520 What kind of heating system is required? (1) Rooms used by clients in a shelter must be equipped with a safe and adequate source of heat that can keep the room at a healthful temperature during the time the room is occupied.

(2) The use of gas or oil-fired space heaters is prohibited.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0520, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0530 How must I ventilate the shelter? You must ensure that your shelter is ventilated for the

health and comfort of the clients residing in shelter, by meeting the following requirements:

(1) A mechanical exhaust to the outside must ventilate toilets and bathrooms that do not have windows opening to the outside.

(2) Bedrooms and communal living areas must have a window or opening to the outdoors that can be locked or secured from the inside.

(3) Gas or oil-fired water heaters and forced-air systems must be safely vented to the outside.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0530, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0540 How much lighting is required in the shelter? You must locate light fixtures and provide lighting that promotes good visibility and comfort for clients residing in shelter.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0540, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0550 Are there any requirements about pets in the shelter? Pets are prohibited from the kitchen during food preparation.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0550, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0560 What first-aid supplies must I approve? You must keep first-aid supplies on hand and accessible to clients residing in shelter for immediate use. First-aid supplies must include at a minimum the following: First-aid instruction booklet, band-aids, sterile gauze, adhesive tape, antibiotic ointment single use packets, antiseptic wipe single use packets, hydrocortisone ointment single use packets, roller bandage, thermometer (nonmercury/nonglass), and nonlatex gloves. In instances where an adult or child has ingested a potentially poisonous chemical or substance, you must call the Washington Poison Center for further instruction.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0560, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0570 What are the requirements for storing medications? (1) Clients residing in shelter must be provided with a means to safely and securely store, and have direct and immediate access to, their medications such as individual lock boxes, lockers with a key or combination lock, or a similar type of secure storage.

(2) All medications, including pet medications and herbal remedies, must be stored in a way that is inaccessible to children.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0570, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0580 What measures must I take for pest control? You must make reasonable attempts to keep the shelter free from pests, such as rodents, flies, cockroaches, fleas and other insects.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0580, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0590 What are the requirements for labeling and storing chemicals and toxic materials? (1) Containers of chemical cleaning agents and other toxic materials must:

(a) Be clearly labeled with the contents.

(b) Bear the manufacturer's instructions and precautions for use.

(2) You must store the following items in a place that is not accessible to children:

(a) Chemical cleaning supplies.

(b) Toxic substances.

(c) Poisons.

(d) Aerosols.

(e) Items with warning labels.

(3) You must store chemical cleaning supplies, toxic substances, and poisons separately from food items, clothing, and bedding in order to prevent contamination.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0590, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0600 Where do I keep firearms and other dangerous weapons? (1) You must keep firearms and other dangerous weapons in a locked storage container, gun safe, or another storage area made of strong, unbreakable material. Stored firearms must be unloaded.

(2) If the storage cabinet has a glass or another breakable front, you must secure the firearms with a locked cable or chain placed through the trigger guards.

(3) You must store ammunition in a place that is separate from the firearms or locked in a gun safe.

(4) You must allow access to firearms, weapons and ammunition only to authorized persons.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0600, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0620 What are the additional standards for shelter homes? Shelter homes must meet the following additional standards in order for a domestic violence agency to contract with us:

(1) Shelter homes must provide at least one toilet, sink, and bathing facility for each fifteen clients or fraction of this number. The floors of all toilet and bathing facilities must be resistant to moisture.

(2) You must have at least one telephone at the shelter for incoming and outgoing calls. Next to the telephone in shelter homes you must post in English and other languages predominantly served by the domestic violence agency:

(a) Emergency telephone numbers.

(b) Instructions on how shelter residents can access domestic violence agency staff.

(3) In shelter homes all bathrooms, toilet rooms, laundry rooms, and janitor closets containing wet mops and brushes must have natural or mechanical ventilation in order to prevent objectionable odors and condensation.

(4) When staff serve food to clients in shelter homes, the staff must prepare the food in compliance with chapter 246-215 WAC, Temporary food service establishment.

(5) Shelter homes must request an annual fire and life safety inspection from their local fire department or fire marshal. The domestic violence agency must maintain documentation of the request as well as any report issued as a result of

the inspection. Any violations noted by the inspector must be immediately corrected by the domestic violence agency.

(6) Shelter homes must meet the following requirements for bedrooms:

(a) Bedrooms must have a minimum ceiling height of seven and one-half feet.

(b) Bedrooms must provide at least fifty square feet of usable floor area per bed.

(c) Floor area where the ceiling height is less than five feet cannot be considered as usable floor area.

(7) When clients are residing in a shelter home at least one domestic violence agency staff member must be present or on-call to go to the shelter home twenty-four hours a day, seven days per week.

(8) When a shelter home is not a component of a domestic violence agency, the shelter home and domestic violence agency must have a written working agreement before the shelter home receives clients from the domestic violence agency. At a minimum, the written working agreement must include:

(a) Confirmation that the domestic violence agency has inspected the shelter home and that the shelter home complies with the general facility and additional standards for shelter homes.

(b) How supportive services will be provided to clients residing in shelter, and who will provide the supportive services.

(c) Verification that the staff providing supportive services, and staff supervisors, meet the training and experience requirements outlined in this rule.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0620, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0630 What are the additional standards for safe homes? Safe homes must meet the following additional standards in order for a domestic violence agency to contract with us:

(1) A prospective safe home must complete a written application to a domestic violence agency. The domestic violence agency must approve the application and provide training to the safe home staff before the home may receive clients.

(2) The domestic violence agency must maintain a written record of all safe homes. The record must include:

(a) The name and address of the person operating the safe home or an identification code for the safe home.

(b) A written safe home application.

(c) Documentation that the safe home complies with the general facility and additional standards for safe homes.

(d) Verification that safe home staff received initial basic training as outlined in this WAC by the domestic violence agency.

(3) You must have at least one telephone at the safe home for incoming and outgoing calls. You must provide the following information to clients residing in a safe home:

(a) Emergency telephone numbers.

(b) Instructions on how clients can access domestic violence agency staff.

(4) When clients are residing in a safe home at least one domestic violence agency staff member must be on-call to go to the safe home twenty-four hours a day, three hundred sixty-five days a year.

(5) Safe homes must comply with the following general fire safety requirements:

(a) Every room used by children in the safe home must have easy entry and exit, including one of these features:

(i) Two separate doors.

(ii) One door leading directly to the outside, or a window that opens to the outside and is large enough for emergency escape or rescue.

(b) Every occupied area must have access to at least one exit that does not pass through rooms or spaces that can be locked or blocked from the opposite side.

(c) No space may be lived in by a client that is accessible only by a ladder, folding stairs, or a trap door.

(d) Every bathroom door used by clients must be designed to permit the opening of the locked door from the outside.

(e) Every closet door latch must be designed to be opened from the inside.

(f) Escape and exit routes must be kept clear and must not be blocked by appliances, furniture, or other heavy objects.

(g) Flammable, combustible, or poisonous material must be stored away from exits and away from areas that are accessible to children.

(h) Open-flame devices and fireplaces, heating and cooking appliances, and products capable of igniting clothing must not be left unattended or used incorrectly.

(i) Fireplaces, wood stoves and other heating systems that have a surface hot enough to cause harm must have gates or protectors around them when in use.

(j) Multilevel dwellings must have a means of escape from an upper floor. If a fire ladder is needed to escape from an upper story window, it must be stored in a location that is easily accessible to the clients who may need it.

(k) You must place a smoke detector in good working condition in each bedroom or in areas close to where children sleep, such as a hallway. If the smoke detector is mounted on the wall, it must be twelve inches from the ceiling and a corner.

(l) If questions arise concerning fire danger, the local fire protection authority must be consulted.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0630, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0640 Will DSHS do an evaluation of the domestic violence agency? (1) To measure compliance with our requirements we will conduct a biennial evaluation of each agency under contract with us to provide domestic violence services.

(2) We will inspect a random number of safe homes during on-site evaluations of domestic violence agencies to measure compliance with our requirements.

(3) If a lodging unit is occupied at the time of an on-site evaluation, the domestic violence agency must give the client an opportunity to leave the unit prior to the arrival of the evaluator.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0640, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0650 What will happen if I am out of compliance with the minimum standards or my contracts? (1) If we find that the domestic violence agency is out of compliance with the standards specified in this chapter or the terms of the DSHS contract, we will give you written notice of the deficiencies. You must correct the deficiencies according to a plan of correction we approve.

(2) We may suspend or revoke the funding of a domestic violence agency if it is out of compliance with this chapter or the DSHS contract.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0650, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0660 What will happen if there is a complaint to DSHS about the domestic violence agency? (1) If we receive a complaint that your domestic violence agency is out of compliance with this chapter or the DSHS contract, we will notify you and we will initiate an investigation.

(2) If the investigation requires that we be on-site at your domestic violence agency, you must give clients residing in lodging units an opportunity to leave the unit during the inspection.

(3) If we find that the domestic violence agency is out of compliance with the standards specified in this chapter or the terms of the DSHS contract, we will give you written notice of the deficiencies. You must correct the deficiencies according to a plan of correction we approve.

(4) We may suspend or revoke the funding of a domestic violence agency if it is out of compliance with this chapter or the DSHS contract.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0660, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0670 Can DSHS waive any of the minimum standards of this chapter? Under certain conditions we may waive some of the rules contained in this chapter.

(1) To request a waiver you must submit a written request that:

(a) Clearly describes the minimum standards(s) for which the waiver is requested.

(b) Describes why the domestic violence agency is unable to meet the requirements of this chapter without the waiver.

(c) Demonstrates that granting of the waiver will not jeopardize the safety or health of clients.

(d) Shows that the absence of granting the waiver will have a detrimental effect on the provision of services.

(2) If the written waiver request proposes any substitutions of procedures, materials, service, or equipment from those specified in this chapter, the substitutions must be at least equivalent to those required.

[Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0670, filed 10/27/10, effective 11/27/10.]

Chapter 388-71 WAC
HOME AND COMMUNITY SERVICES AND PROGRAMS

WAC

388-71-0515 What are the responsibilities of an individual provider or home care agency provider when employed to provide care to a client?
388-71-0540 When will the department, AAA, or department designee deny payment for services of an individual provider or home care agency provider?

WAC 388-71-0515 What are the responsibilities of an individual provider or home care agency provider when employed to provide care to a client? An individual provider or home care agency provider must:

(1) Understand the client's plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;

(2) Provide the services as outlined on the client's plan of care, as defined in WAC 388-106-0010;

(3) Accommodate client's individual preferences and differences in providing care;

(4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the plan of care;

(5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;

(6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;

(7) Notify the case manager immediately if the client dies;

(8) Notify the department or AAA immediately when unable to staff/serve the client; and

(9) Notify the department/AAA when the individual provider or home care agency will no longer provide services. Notification to the client/legal guardian must:

(a) Give at least two weeks' notice, and

(b) Be in writing.

(10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and

(11) Comply with all applicable laws and regulations.

(12) A home care agency must not bill the department for in-home medicaid funded personal care or DDD respite services when the agency employee providing care is a family member of the client served, unless approved to do so through an exception to rule under WAC 388-440-0001. For purposes of this section, family member means related by blood, marriage, adoption, or registered domestic partnership.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 571, and Washington state 2009-11 budget, section 206(17). 10-06-112, § 388-71-0515, filed 3/3/10, effective 4/3/10. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0515, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. 02-21-098, § 388-71-0515, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0515, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.-050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0515, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0540 When will the department, AAA, or department designee deny payment for services of an

individual provider or home care agency provider? The department, AAA, or department designee will deny payment for the services of a home care agency provider if the services are provided by an employee of the home care agency who is related by blood, marriage, adoption, or registered domestic partnership to the client.

The department, AAA, or department designee will deny payment for the services of an individual provider or home care agency provider who:

(1) Is the client's spouse, per 42 C.F.R. 441.360(g), except in the case of an individual provider for a chore services client. Note: For chore spousal providers, the department pays a rate not to exceed the amount of a one-person standard for a continuing general assistance grant, per WAC 388-478-0030;

(2) Is the natural/step/adoptive parent of a minor client aged seventeen or younger receiving services under medicaid personal care;

(3) Is a foster parent providing personal care to a child residing in their licensed foster home;

(4) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830;

(5) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW;

(6) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations;

(7) Does not successfully complete the training requirements within the time limits required in WAC 388-71-05665 through 388-71-05865;

(8) Is already meeting the client's needs on an informal basis, and the client's assessment or reassessment does not identify any unmet need; and/or

(9) Is terminated by the client (in the case of an individual provider) or by the home care agency (in the case of an agency provider).

In addition, the department, AAA, or department designee may deny payment to or terminate the contract of an individual provider as provided under WAC 388-71-0546, 388-71-0551, and 388-71-0556.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 571, and Washington state 2009-11 budget, section 206(17). 10-06-112, § 388-71-0540, filed 3/3/10, effective 4/3/10. Statutory Authority: RCW 74.08.090, 74.09.520. 07-24-026, § 388-71-0540, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-71-0540, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0540, filed 5/17/05, effective 6/17/05. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-0540, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.-090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0540, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0540, filed 1/13/00, effective 2/13/00.]

Chapter 388-76 WAC

ADULT FAMILY HOME MINIMUM LICENSING REQUIREMENTS

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-76-10155 Unsupervised access to vulnerable adults—Prohibited. [Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10155, filed 10/16/07, effective 1/1/08.] Repealed by 10-16-082, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040, chapter 74.39A RCW.

388-76-10173 Disclosure of employee information—Employer immunity—Rebuttable presumption. [Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10173, filed 1/12/09, effective 2/12/09.] Repealed by 10-16-082, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040, chapter 74.39A RCW.

388-76-10185 Employment—Certain criminal history—Permitted. [Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10185, filed 10/16/07, effective 1/1/08.] Repealed by 10-04-008, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040.

388-76-10190 Adult family home—Compliance with regulations—Required. [Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10190, filed 10/16/07, effective 1/1/08.] Repealed by 10-03-064, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040.

WAC 388-76-10000 Definitions. "Abandonment" means action or inaction by a person or entity with a duty of care for a frail elder or vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult:

(1) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain or mental anguish; and

(2) Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) **"Sexual abuse"** means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not consensual.

(b) **"Physical abuse"** means a willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or chemical or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

(c) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) **"Exploitation"** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

"Adult family home" means:

(1) A residential home in which a person or an entity is licensed to provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to a licensed operator, resident manager, or caregiver, who resides in the home.

(2) As used in this chapter, the term "entity" includes corporations, partnerships and limited liability companies, and the term "adult family home" includes the person or entity that is licensed to operate an adult family home.

"Affiliated with an applicant" means any person listed on the application as a partner, officer, director, resident manager, or majority owner of the applying entity, or is the spouse or domestic partner of the applicant.

"Applicant" means an individual, partnership, corporation, or other entity seeking a license to operate an adult family home.

"Capacity" means the maximum number of persons in need of personal or special care who are permitted to reside in an adult family home at a given time. The capacity includes:

(1) The number of related children or adults in the home who receive personal or special care and services; plus

(2) The number of residents the adult family home may admit and retain - the resident capacity. The capacity number listed on the license is the "resident capacity."

"Caregiver" means any person eighteen years of age or older responsible for providing direct personal or special care to a resident and who is not the provider, entity representative, a student or volunteer.

"Dementia" is defined as a condition documented through the assessment process required by WAC 388-76-10335.

"Department" means the Washington state department of social and health services.

"Department case manager" means the department authorized staff person or designee assigned to negotiate, monitor, and facilitate a care and services plan for residents receiving services paid for by the department.

"Developmental disability" means:

(1) A person who meets the eligibility criteria defined by the division of developmental disabilities under WAC 388-823-0040; or

(2) A person with a severe, chronic disability which is attributable to cerebral palsy or epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation which results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, and requires treatment or services similar to those required for these persons (i.e., autism); and

(a) The condition was manifested before the person reached age eighteen;

(b) The condition is likely to continue indefinitely; and

(c) The condition results in substantial functional limitations in three or more of the following areas of major life activities:

(i) Self-care;

(ii) Understanding and use of language;

(iii) Learning;

(iv) Mobility;

(v) Self-direction; and

(vi) Capacity for independent living.

"Direct supervision" means oversight by a person who has demonstrated competency in the basic training and specialty training if required, or who has been exempted from the basic training requirements and is:

(1) On the premises; and

(2) Quickly and easily available to the caregiver.

"Domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage other than for the vulnerable adult's profit or advantage.

"Entity representative" means the individual designated by a provider who is or will be responsible for the daily operation of the adult family home and who meets the requirements of this chapter and chapter 388-112 WAC.

"Home" means adult family home.

"Indirect supervision" means oversight by a person who:

(1) Has demonstrated competency in the basic training and specialty training if required; or

(2) Has been exempted from the basic training requirements; and

(3) Is quickly and easily available to the care giver, but not necessarily on-site.

"Inspection" means a review by department personnel to determine the adult family home's compliance with this chapter and chapters 70.128, 70.129, 74.34 RCW, and other applicable rules and regulations. The department's review may include an on-site visit.

"Management agreement" means a written, executed agreement between the adult family home and another individual or entity regarding the provision of certain services on behalf of the adult family home.

"Mandated reporter" means an employee of the department, law enforcement, officer, social worker, professional school personnel, individual provider, an employee of a facility, an employee of a social service, welfare, mental health, adult day health, adult day care, or hospice agency, county coroner or medical examiner, Christian Science practitioner, or health care provider subject to chapter 18.130 RCW. For the purpose of the definition of a mandated reporter, **"Facility"** means a residence licensed or required to be licensed under chapter 18.20 RCW (Boarding homes), chapter 18.51 RCW (Nursing homes), chapter 70.128 RCW (Adult family homes), chapter 72.36 RCW (Soldiers' homes), chapter 71A.20 RCW (Residential habilitation centers), or any other facility licensed by the department.

"Medical device" as used in this chapter, means any piece of medical equipment used to treat a resident's assessed need.

(1) A medical device is not always a restraint and should not be used as a restraint;

(2) Some medical devices have considerable safety risks associated with use; and

(3) Examples of medical devices with known safety risks when used are transfer poles, Posey or lap belts, and side rails.

"Medication administration" means giving resident medications by a person legally authorized to do so, such as a physician, pharmacist or nurse.

"Medication organizer" is a container with separate compartments for storing oral medications organized in daily doses.

"Mental illness" is defined as an Axis I or II diagnosed mental illness as outlined in volume IV of the Diagnostic and Statistical Manual of Mental Disorders (a copy is available for review through the aging and disability services administration).

"Multiple facility provider" means a provider who is licensed to operate more than one adult family home.

"Neglect" means:

(1) A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

(2) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

"Nurse delegation" means a registered nurse transfers the performance of selected nursing tasks to competent nursing assistants in selected situations. The registered nurse delegating the task retains the responsibility and accountability for the nursing care of the resident.

"Over-the-counter medication" is any medication that can be purchased without a prescriptive order, including but not limited to vitamin, mineral, or herbal preparations.

"Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs and does not include assistance with tasks performed by a licensed health professional.

"Physical restraint" means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement or access to his or her body, is used for discipline or convenience, and is not required to treat the resident's medical symptoms.

"Practitioner" includes a physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant licensed in the state of Washington.

"Prescribed medication" refers to any medication (legend drug, controlled substance, and over-the-counter) that is prescribed by an authorized practitioner.

"Provider" means:

(1) Any person who is licensed to operate an adult family home and meets the requirements of this chapter; or

(2) Any corporation, partnership, or limited liability company that is licensed under this chapter to operate an adult family home and meets the requirements of this chapter.

"Resident" means any adult unrelated to the provider who lives in the adult family home and who is in need of care. Except as specified elsewhere in this chapter, for decision-making purposes, the term "resident" includes the resident's surrogate decision maker acting under state law.

"Resident manager" means a person employed or designated by the provider to manage the adult family home and who meets the requirements of this chapter.

"Significant change" means:

(1) A lasting change, decline or improvement in the resident's baseline physical, mental or psychosocial status;

(2) The change is significant enough so the current assessment and/or negotiated care plan do not reflect the resident's current status; and

(3) A new assessment may be needed when the resident's condition does not return to baseline within a two week period of time.

"Special care" means care beyond personal care services as defined in this section.

"Staff" means any person who:

(1) Is employed or used by an adult family home, directly or by contract, to provide care and services to any resident.

(2) Staff must meet all of the requirements in this chapter and chapter 388-112 WAC.

"Unsupervised" means not in the presence of:

(1) Another employee or volunteer from the same business or organization; or

(2) Any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the employee, student or volunteer has access during the course of his or her employment or involvement with the business or organization.

"Usable floor space" means resident bedroom floor space exclusive of:

(1) Toilet rooms;

(2) Closets;

(3) Lockers;

(4) Wardrobes;

(5) Vestibules, and

(6) The space required for the door to swing if the bedroom door opens into the resident bedroom.

"Water hazard" means any body of water over twenty-four inches in depth that can be accessed by a resident, and includes but not limited to:

(1) In-ground, above-ground, and on-ground pools;

(2) Hot tubs, spas;

(3) Fixed-in-place wading pools;

(4) Decorative water features;

(5) Ponds; or

(6) Natural bodies of water such as streams, lakes, rivers, and oceans.

"Willful" means the deliberate or nonaccidental action or inaction by an individual that he/she knew or reasonably should have known could cause a negative outcome, including harm, injury, pain or anguish.

"Vulnerable adult" includes a person:

(1) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself;

(2) Found incapacitated under chapter 11.88 RCW;

(3) Who has a developmental disability as defined under RCW 71A.10.020;

(4) Admitted to any facility;

(5) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW;

(6) Receiving services from an individual provider; or

(7) With a functional disability who lives in his or her own home, who is directing and supervising a paid personal aide to perform a health care task as authorized by RCW 74.39.050.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10000, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10000, filed 1/15/10, effective 2/15/10; 09-03-029, § 388-76-10000, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10000, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10002 Department authority. Under chapter 70.128 RCW, the department is authorized to take actions in response to adult family home noncompliance or violations of requirements of this chapter or rules adopted under chapters 70.128, 70.129, and 74.34 RCW.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10002, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10003 Department access. (1) The applicant must allow the department staff to inspect the entire premises including all of the home's rooms, buildings, grounds, and equipment and all pertinent records during the initial licensing of the home.

(2) During inspections, the adult family home must allow the department staff to examine all areas and articles in the home that are used to provide care or support to residents, including the physical premises and residents' records and accounts. The physical premises includes the buildings, grounds, and equipment. The provider's personal records unrelated to the operation of the adult family home are not subject to department review. The provider's separate bedroom will not be subject to review and inspection unless it is used to provide direct care to a resident.

(3) During complaint investigations, the adult family home must give department staff access to the entire premises and all records related to the residents or operation of the home. Department staff are authorized to interview the provider, family members, and individuals residing in the home including residents.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10003, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10015 License—Adult family home—Compliance required. (1) The licensed adult family home must comply with all the requirements established in chapters 70.128, 70.129, 74.34 RCW, this chapter and other applicable laws and regulations including chapter 74.39A RCW; and

(2) The provider is ultimately responsible for the operation of the adult family home.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10015, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10015, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10020 License—Ability to provide care and services. The provider must have the:

(1) Understanding, ability, emotional stability and physical health necessary to meet the psychosocial, personal, and special care needs of vulnerable adults; and

(2) Ability to meet all personal and business financial obligations.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10020, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10020, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10030 License capacity. (1) The adult family home capacity includes:

(a) The number of residents which is the resident capacity; plus

(b) The number of related children or adults in the home who receives personal or special care services.

(2) In determining the home's resident capacity, the department must consider the:

(a) Structural design of the house;

(b) Number and accessibility of bathrooms;

(c) Number and qualifications of staff;

(d) Total number of people living in the home who require personal or special care, including:

(i) Related children and adults; and

(ii) Other household members;

(e) The number of people for whom the home provides adult day care; and

(f) The ability for the home to safely evacuate all people living in the home.

(3) The resident capacity number will be listed on the adult family home license and the home must ensure that the number of residents in the home does not exceed the resident capacity.

(4) The adult family home resident capacity may be adjusted due to changes to the household mix or structure.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10030, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10030, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10035 License requirements—Multiple family home providers. To be licensed to operate more than one adult family home, the applicant must have:

(1) Evidence of successful completion of the forty-eight hour residential care administrator's training to meet the applicable requirements of chapter 388-112 WAC.

(2) Operated an adult family home in Washington for at least one year without a significant violation of chapters 70.128, 70.129 or 74.34 RCW, this chapter or other applicable laws and regulations; and

(3) The ability to operate more than one home.

(4) The following plans for each home the applicant intends to operate:

(a) A twenty-four hour a day, seven day a week staffing plan;

(b) A plan for managing the daily operations of each home; and

(c) A plan for emergencies, deliveries, staff and visitor parking.

(5) A credit history considered if the history relates to the ability to provide care and services.

(6) An entity representative or a resident manager at each home who is responsible for the care of each resident at all times.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10035, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10035, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10036 License requirements—Multiple adult family home management. When there is more than one home licensed to a provider, the adult family home must ensure that:

(1) Each home has one person responsible for managing the overall delivery of care to all residents in the home;

(2) The designated responsible person is the provider, entity representative or a resident manager; and

(3) Each responsible person is designated to manage only one adult family home at a given time.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10036, filed 1/22/10, effective 2/22/10; 09-03-030, § 388-76-10036, filed 1/12/09, effective 2/12/09.]

WAC 388-76-10040 License requirements—Qualified person must live-in or be on-site. (1) The adult family home provider or entity representative must:

(a) Live in the home; or

(b) Employ or contract with a resident manager who lives in the home and is responsible for the care and services of each resident at all times.

(2) The provider, entity representative, or resident manager is exempt from the requirement to live in the home if:

(a) The home has twenty-four hour staffing coverage; and

(b) A staff person who can make needed decisions is always present in the home.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10040, filed 1/22/10, effective 2/22/10; 09-03-030, § 388-76-10040, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10040, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10050 License—Relinquishment. (1) If an adult family home does not have any residents, it may relinquish its license at any time.

(2) The home must relinquish its license if it has not provided care and services to residents for twenty-four months.

(3) The department may revoke the adult family home license if:

(a) The home does not relinquish the license as required under subsection (2); and

(b) There is no credible evidence that residents were cared for in the home during the period of time specified in subsection (2).

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10050, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10050, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10055 Application—Generally. The applicant must send an application to the department for:

(1) An initial adult family home license;

(2) A change of ownership of the adult family home; or

(3) A change of the adult family home location or address.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10055, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10055, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10057 Application—General qualifications. Before sending the application to the department, the applicant must ensure that the people listed on the application meet any applicable minimum qualifications listed in WAC 388-76-10130 through 388-76-10145.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10057, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10063 Application—General training requirements. An applicant must ensure that each person listed on the application has successfully completed the training if required under this chapter and chapter 388-112 WAC.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10063, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10064 Application—Forty-eight hour class training requirements. (1) The applicant, and the entity representative must successfully complete the department approved forty-eight hour adult family home administration and business planning class as required in chapter 388-112 WAC.

(2) An applicant and entity representative may not be required to take the forty-eight hour class if there is a change in ownership and the applicant and entity representative are already participants in the operation of a currently licensed home.

(3) An applicant and entity representative must take the forty-eight hour class when the application is for an additional licensed home and the forty-eight hour class has not already been successfully taken.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10064, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10080 Application—Coprovider. Couples who are legally married or domestic partners under Washington state law:

(1) May not apply for separate licenses; and

(2) May apply jointly to be coproviders.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10080, filed 1/15/10, effective 2/15/10; 09-03-030, § 388-76-10080, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10080, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10090 Application—Entity application. An entity submitting an application must:

(1) Include a list of all facilities or homes in which the applicant or persons affiliated with the applicant, managerial employee, or owner of five percent or more of the entity provided care and services to children or vulnerable adults within the last ten years;

(2) Designate an entity representative who:

(a) Is responsible for the daily operations of the adult family home;

(b) Will be considered the department's primary contact person; and

(c) May act as both the entity representative and the resident manager in only one home.

(3) Designate a resident manager for the home if the entity representative is not the designated resident manager in subsection (2)(c) of this section.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10090, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10090, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10105 Application—Change of ownership. (1) Under this section, "control of the provider" means the possession, directly or indirectly, of the power to direct the management, operation and/or policies of the adult family home, whether through ownership, voting control, by agreement, by contract or otherwise.

(2) A change of ownership of an adult family home requires both a new license application and a new license.

(3) A change of ownership occurs when there is a change in:

(a) The provider; or

(b) The control of a provider.

(4) Events which constitute a change of ownership include, but are not limited to:

(a) The form of legal organization of the adult family home is changed, such as when an adult family home forms:

(i) A partnership;

(ii) A corporation;

(iii) A limited liability company; or

(iv) When it merges with another legal organization.

(b) The adult family home transfers business operations and management responsibility to another party, whether or not there is a partial or whole transfer of real property, personal property, or both.

(c) Two people are both licensed as a married couple or domestic partners to operate an adult family home and an event, such as a separation, divorce, or death, results in only one person operating the home.

(d) Dissolution of a business partnership that is licensed to operate the adult family home.

(e) If the adult family home is a corporation and the corporation:

(i) Is dissolved;

(ii) Merges with another corporation, resulting in a change in the control of the provider; or

(iii) Consolidates with one or more corporations to form a new corporation;

(iv) Whether by a single transaction or multiple transactions within a continuous twenty-four month period, transfers fifty percent or more of its shares to one or more of the following:

(A) New or former shareholders; or

(B) Present shareholders, each having less than five percent of the shares before the initial transaction.

(f) Any other event or combination of events that results in a substitution, elimination, or withdrawal of the provider's control of the adult family home.

(5) The new owner:

(a) Must obtain a new license from the department before transfer of ownership;

(b) Must not begin operation of the adult family home until the department has granted the license;

(c) Must correct all deficiencies that exist at the time of the ownership change;

(d) Is subject to the provisions of chapters 70.128, 70.129, 74.34 RCW, this chapter and other applicable laws and regulations; and

(e) Must provide the department with a copy of the written notice of the change of ownership that was given to each resident, or applicable resident representatives.

[Statutory Authority: RCW 70.128.040. 10-14-058, § 388-76-10105, filed 6/30/10, effective 7/31/10; 10-04-008, § 388-76-10105, filed 1/22/10, effective 2/22/10; 09-03-030, § 388-76-10105, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10105, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10106 Change of ownership—Notice to department and residents. (1) The current adult family home owner must provide written notice to the department, residents or applicable resident representatives, sixty calendar days prior to the date of the proposed change of ownership; and

(2) The home must include the following information in the written notice:

(a) Names of the present owner and prospective owner;

(b) Name and address of the adult family home for which the ownership is being changed;

(c) Date of proposed change;

(d) The resident's right to decide whether they want to stay or move; and

(e) Any change in the home's policies or operations that could impact a resident's ability to continue to live in the home. For example, if the new owner will be changing the home's policy on serving medicaid eligible residents, that change might impact a resident's ability to continue receiving services in the home.

[Statutory Authority: RCW 70.128.040. 10-14-058, § 388-76-10106, filed 6/30/10, effective 7/31/10.]

WAC 388-76-10107 Change of ownership—Priority processing. In order to prevent disruption to residents, currently licensed providers may request in writing that the department give priority processing to an applicant seeking to be licensed as the new provider for the adult family home.

[Statutory Authority: RCW 70.128.040. 10-14-058, § 388-76-10107, filed 6/30/10, effective 7/31/10.]

WAC 388-76-10110 Application—Change of location or address. (1) A change of the adult family home location or address requires both a new license application and a new license.

(2) The home must not start operations of the home at a new location until the department has granted the license for the new location.

(3) The home must notify each resident or resident representative, in writing at least thirty days before the effective date of the change of the home location or address.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10110, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10110, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10115 Granting or denying a license—Generally. In making a determination of whether to grant an adult family home license, the department must consider:

(1) Separately and jointly each person and entity named in an application, including each person or entity affiliated with the applicant;

(2) Information in the application;

(3) Other documents and information the department deems relevant which may include, but not be limited to:

(a) Inspection and complaint investigation findings in each facility or home in which the applicant, person affiliated with the applicant, or owner of five percent or more of the entity provided care or services to children or vulnerable adults; and

(b) Credit information.

(4) The history of convictions and other circumstances described in WAC 388-76-10120 and 388-76-10125 for each individual listed on the application including, but not limited to the following:

(a) Applicant;

(b) Person affiliated with the applicant;

(c) Entity representative;

(d) Caregiver;

(e) An owner who:

(i) Exercised daily control over the operations; or

(ii) Owns fifty-one percent or more of the entity.

(f) Any person who may have unsupervised access to residents in the home; and

(g) Any person who lives in the home and is not a resident.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10115, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10115, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10120 License—Must be denied. The adult family home license will not be granted if:

(1) The applicant has not successfully completed a department-approved forty-eight hour adult family home administration and business planning class except as provided in WAC 388-76-10064.

(2) It has been less than twenty years since the applicant surrendered or relinquished an adult family home license after receiving notice that the department intended to deny, suspend, not renew or revoke the license.

(3) The applicant or the applicant's spouse, domestic partner, or any partner, officer, director, managerial employee or majority owner of the applying entity:

(a) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults;

(b) Has been convicted of a crime in federal court or in any other state, and the department determines that the crime is equivalent to a crime under subsections (3)(c), (d), (e), (f), or (g) below;

(c) Has been convicted of a "crime against children or other persons" as defined in RCW 43.43.830, unless the crime is simple assault, assault in the fourth degree, or prostitution and more than three years has passed since conviction;

(d) Has been convicted of "crimes relating to financial exploitation" as defined in RCW 43.43.830, unless the crime is theft in third degree and more than three years have passed since conviction, or unless the crime is forgery or theft in the second degree and more than five years has passed since conviction;

(e) Has been convicted of:

(i) Violation of the Imitation Controlled Substance Act (VICSA);

(ii) Violation of the Uniform Controlled Substances Act (VUCSA);

(iii) Violation of the Uniform Legend Drug Act (VULDA); or

(iv) Violation of the Uniform Precursor Drug Act (VUPDA).

(f) Has been convicted of sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;

(g) Has been convicted of criminal mistreatment;

(h) Has been found to have abused, neglected, exploited, or abandoned a minor or vulnerable adult by court of law or a disciplining authority, including the department of health. Examples of legal proceedings in which such findings could be made include juvenile court proceedings under chapter 13.34 RCW, domestic relations proceeding under Title 26 RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW;

(i) Has a finding of abuse or neglect of a child that is:

(i) Listed on the department's background check central unit (BCCU) report; or

(ii) Disclosed by the individual, except for findings made before December, 1998.

(j) Has a finding of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult that is:

(i) Listed on any registry, including the department's registry;

(ii) Listed on the department's background check central unit (BCCU) report; or

(iii) Disclosed by the individual, except for adult protective services findings made before October, 2003.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10120, filed 1/15/10, effective 2/15/10; 09-03-028, § 388-76-10120, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10120, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10125 License—May be denied. The adult family home license may be denied if the applicant or the applicant's spouse, domestic partner, or any partner, officer, director, managerial employee or majority owner of the applying entity:

(1) Has been convicted of:

(a) Simple assault, theft in third degree, assault in the fourth degree, or prostitution and more than three years has passed since conviction;

(b) Forgery or theft in the second degree and more than five years has passed since conviction;

(c) Any felony that the department determines is reasonably related to the competency of the person to be involved in the ownership or operation of an adult family home; or

(d) A crime involving a firearm used in commission of a felony or in any act of violence against a person.

(2) Has engaged in the illegal use, sale or distribution of drugs or excessive use of alcohol or drugs without the evidence of rehabilitation;

(3) Has committed an act of domestic violence toward a family or household member;

(4) Has been found in any final decision of a federal or state agency to have abandoned, neglected, abused or financially exploited a vulnerable adult, unless such decision requires a license denial under WAC 388-76-10120;

(5) Has had a license for the care of children or vulnerable adults denied, suspended, revoked, or not renewed;

(6) Has a history of prior violations of chapter 70.128 RCW or any law regulating residential care facilities that resulted in revocation, suspension, or nonrenewal of a license;

(7) Has been enjoined from operating a facility for the care and services of children or adults;

(8) Has had a medicaid or medicare provider agreement or any other contract for the care and treatment of children or vulnerable adults, terminated, cancelled, suspended, or not renewed by any public agency, including a state medicaid agency;

(9) Has been the subject of a sanction or corrective or remedial action taken by federal, state, county, or municipal officials or safety officials related to the care or treatment of children or vulnerable adults;

(10) Has obtained or attempted to obtain a license by fraudulent means or misrepresentation;

(11) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a license or any data attached to the application, or in any matter involving the department;

(12) Permitted, aided, or abetted the commission of any illegal act on the adult family home premises;

(13) Willfully prevented or interfered with or failed to cooperate with any inspection, investigation, or monitoring visit made by the department, including refusal to permit authorized department representatives to interview residents or have access to their records;

(14) Failed or refused to comply with:

(a) A condition imposed on a license or a stop placement order; or

(b) The requirements of chapters 70.128, 70.129, 74.34 RCW, this chapter or other applicable laws and regulations.

(15) Misappropriated property of a resident, unless such action requires a license denial under WAC 388-76-10120;

(16) Exceeded licensed capacity in the operation of an adult family home;

(17) Operated a facility for the care of children or adults without a license or with a revoked license;

(18) In connection with the operation of any facility for the care of children or adults, relinquished or returned a license, or did not seek license renewal following written notification that the licensing agency intended to deny, suspend, or revoke the license, unless such action requires a license denial under WAC 388-76-10120;

(19) When providing care to children or vulnerable adults, has had resident trust funds or assets seized by the Internal Revenue Service or a state entity for failure to pay income or payroll taxes;

(20) Failed to meet financial obligations as the obligations fell due in the normal course of owning or operating a business involved in the provision of care and services to children or vulnerable adults;

(21) Has failed to meet personal financial obligations;

(22) Interfered with a long-term care ombudsman or department staff in the performance of his or her duties;

(23) Has not demonstrated financial solvency or management experience in its currently licensed homes, or has not demonstrated the ability to meet other relevant safety, health, and operating standards pertaining to the operation of multiple homes, including ways to mitigate the potential impact of vehicular traffic related to the operation of the homes; or

(24) The home is currently licensed:

(a) As a boarding home; or

(b) To provide care for children in the same home, unless:

(i) It is necessary in order to allow a resident's child(ren) to live in the same home as the resident or to allow a resident who turns eighteen to remain in the home;

(ii) The applicant provides satisfactory evidence to the department of the home's capacity to meet the needs of children and adults residing in the home; and

(iii) The total number of persons receiving care and services in the home does not exceed the number permitted by the licensed capacity of the home.

(25) Failed to give the department access to all parts of the home as authorized under RCW 70.128.090.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10125, filed 1/15/10, effective 2/15/10; 09-03-028, § 388-76-10125, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10125, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10129 Qualifications—Adult family home personnel. The adult family home must ensure that the following are qualified and meet all of the applicable requirements of this chapter and chapter 388-112 WAC:

(1) Any person employed or used by the adult family home, directly or by contract, by an adult family home; including but not limited to:

(a) The provider;

(b) Entity representative;

(c) Resident manager;

(d) Staff; and

(f) Caregivers.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10129, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10130 Qualifications—Provider, entity representative and resident manager. The adult family home must ensure that the provider, entity representative and resident manager have the following minimum qualifications:

(1) Be twenty-one years of age or older;

(2) Have a United States high school diploma or general education development certificate, or any English translated government document of the following:

(a) Successful completion of government approved public or private school education in a foreign country that includes an annual average of one thousand hours of instruction a year for twelve years, or no less than twelve thousand hours of instruction;

(b) Graduation from a foreign college, foreign university, or United States community college with a two-year diploma, such as an associate's degree;

(c) Admission to, or completion of course work at a foreign or United States college or university for which credit was awarded;

(d) Graduation from a foreign or United States college or university, including award of a bachelor's degree;

(e) Admission to, or completion of postgraduate course work at, a United States college or university for which credits were awarded, including award of a master's degree; or

(f) Successful passage of the United States board examination for registered nursing, or any professional medical occupation for which college or university education was required.

(3) Completion of the training requirements that were in effect on the date they were hired, including the requirements described in chapter 388-112 WAC;

(4) Have good moral and responsible character and reputation;

(5) Be literate in the English language, or meet alternative requirements by assuring that a person is on staff and available at the home who is:

(a) Able to communicate or make provisions for communicating with the resident in his or her primary language; and

(b) Capable of understanding and speaking English well enough to be able to respond appropriately to emergency situations and be able to read, understand and implement resident negotiated care plans.

(6) Be able to carry out the management and administrative requirements of chapters 70.128, 70.129 and 74.34 RCW, this chapter and other applicable laws and regulations;

(7) Have completed at least three hundred and twenty hours of successful direct care experience obtained after age eighteen to vulnerable adults in a licensed or contracted setting before operating or managing a home;

(8) Have no criminal convictions listed in RCW 43.43.830 or 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation;

(9) Obtain and keep valid cardiopulmonary resuscitation (CPR) and first-aid card or certificate as required in chapter 388-112 WAC; and

(10) Have tuberculosis screening to establish tuberculosis status per this chapter.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10130, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10130, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10135 Qualifications—Caregiver. The adult family home must ensure each caregiver has the following minimum qualifications:

(1) Be eighteen years of age or older;

(2) Have a clear understanding of the caregiver job responsibilities and knowledge of each resident's negotiated care plan to provide care specific to the needs of each resident;

(3) Have basic communication skills to:

(a) Be able to communicate or make provisions to communicate with the resident in his or her primary language;

(b) Understand and speak English well enough to:

(i) Respond appropriately to emergency situations; and

(ii) Read, understand and implement resident negotiated care plans.

(4) Completion of the training requirements that were in effect on the date they were hired including requirements described in chapter 388-112 WAC;

(5) Have no criminal convictions listed in RCW 43.43.830 or 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation;

(6) Have a current valid first-aid and cardiopulmonary resuscitation (CPR) card or certificate as required in chapter 388-112 WAC; and

(7) Have tuberculosis screening to establish tuberculosis status per this chapter.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10135, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10135, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10146 Qualifications—Training and home care aide certification. (1) The adult family home must ensure all adult family home caregivers, entity representatives, and resident managers hired on or after January 1, 2011, meet the long-term care worker training requirements of chapter 388-112 WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(2) All persons listed in subsection (1) of this section, must obtain the home-care aide certification required by chapter 246-980 WAC.

(3) All adult family home applicants on or after January 1, 2011, must meet the long-term care worker training requirements of chapter 388-112 WAC and obtain the home-care aide certification required by chapter 246-980 WAC.

(4) Under RCW 18.88B.040 and chapter 246-980 WAC, certain persons including registered nurses, licensed practical nurses, certified nursing assistants or persons who are in an approved certified nursing assistant program are exempt from long-term care worker training requirements.

(5) The adult family home must ensure that all staff receive the orientation and training necessary to perform their job duties.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10146, filed 7/30/10, effective 1/1/11.]

WAC 388-76-10160 Background check—General. Background checks conducted by the department and required in this chapter include but are not limited to:

(1) Washington state background checks including:

(a) Department and department of health findings; and

(b) Criminal background check information from the Washington state patrol and the Washington state courts.

(2) After January 1, 2012, a national fingerprint-based check in accordance with RCW 74.39A.055.

(3) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the adult family home.

(4) In addition to chapter 70.128 RCW, these rules are authorized by RCW 43.20A.710, 43.43.830 through 43.43.842 and RCW 74.39A.050(8).

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10160, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10160, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10161 Background check—Washington state—Who is required to have. (1) An adult family home applicant and anyone affiliated with an applicant must have a Washington state background check before licensure.

(2) The adult family home must ensure the following individuals employed directly or by contract, have Washington state background checks:

(a) Caregivers, including volunteers and students who may have unsupervised access to residents;

(b) Entity representatives;

(c) Resident managers; and

(d) All household members over the age of eleven who may have unsupervised access to residents.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10161, filed 7/30/10, effective 1/1/11.]

WAC 388-76-10162 Background check—National fingerprint checks—Who is required to have. (1) After January 1, 2012, an adult family home applicant and anyone affiliated with an applicant, must have a background check that includes a national fingerprint-based background check.

(2) The adult family home must ensure that all caregivers, entity representatives and resident managers hired after January 1, 2012 have a background check that includes a national fingerprint-based background check.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10162, filed 7/30/10, effective 1/1/11.]

WAC 388-76-10163 Background check—Process. Before the adult family home employs, directly or by contract, a resident manager, entity representative or caregiver, or accepts as a caregiver any volunteer or student, or allows a household member over the age of eleven unsupervised access to residents, the home must:

(1) Require the person to complete a DSHS background authorization form; and

(2) Send the completed form to the department's background check central unit (BCCU), including any additional documentation and information requested by the department.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10163, filed 7/30/10, effective 1/1/11.]

WAC 388-76-10164 Background check—Results. (1) The adult family home must not allow persons listed in WAC 388-76-10161(2) to have unsupervised access to residents until the adult family home receives background check results from the department verifying that the person does not have convictions, or findings described in WAC 388-76-10180.

(2) If the background check results show that the person has a conviction or finding that is not disqualifying under WAC 388-76-10180, then the adult family home must determine whether the person has the character, suitability and competence to work with vulnerable adults in long-term care.

(3) The adult family home must:

(a) Inform the person of the results of the background check;

(b) Inform the person that they may request a copy of the results of the background check. If requested, a copy of the background check results must be provided within ten days of the request; and

(c) Notify the department and the other appropriate licensing or certification agency of any person resigning or terminated as a result of having a conviction record.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10164, filed 7/30/10, effective 1/1/11.]

WAC 388-76-10165 Background check—Valid for two years. A Washington state background check is valid for two years from the initial date it is conducted. The adult family home must ensure:

(1) A new DSHS background authorization form is submitted to the BCCU every two years for individuals listed in WAC 388-76-10161;

(2) There is a valid Washington state background check for all individuals listed in WAC 388-76-10161.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10165, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10165, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10170 Background check—Confidentiality—Use restricted—Retention. The adult family home must establish and implement procedures that ensure all background authorization forms, background check results, related information, and all copies are:

(1) Kept in a confidential and secure manner;

(2) Used for employment purposes only;

(3) Not disclosed to any person except:

(a) The person about whom the home made the disclosure or background check;

(b) Licensed facilities, an employer of an authorized program, or an in-home services agency employer identified in WAC 388-76-10174;

(c) Authorized state and federal employees; and

(d) The Washington state patrol auditor.

(4) Kept for two years after the date an employee either quits or is terminated.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10170, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10170, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10170, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10174 Background check—Disclosure of information—Sharing of background information by health care facilities. In accordance with RCW 43.43.832 a health care facility may share Washington state background check results with other health care facilities under certain circumstances. Results of the national fingerprint-based background check may not be shared. For the purposes of this section health care facility means a nursing home licensed under chapter 18.51 RCW, a boarding home licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

(1) A health care facility may, upon request from another health care facility, share completed Washington state background check results only if:

(a) The health care facility sharing the background check information is reasonably known to be the person's most recent employer;

(b) No more than twelve months has elapsed between the date the person was last employed at a licensed health care facility and the date of the person's current employment application; and

(c) The background check is no more than two years old.

(2) If background check information is shared, the health care facility employing the subject of the check must require the applicant to sign a disclosure statement indicating that there has been no conviction or finding as described in WAC

388-76-10180 since the completion date of the most recent background check.

(3) Any health care facility that knows or has reason to believe that an applicant has or may have a disqualifying conviction or finding as described in WAC 388-76-10180, after the completion date of their most recent background check:

(a) Cannot rely on the applicant's previous employer's background check information; and

(b) Must request a new background check as required by this chapter.

(4) Health care facilities that share background check information shall be immune from any claim of defamation, invasion of privacy, negligence, or any other claim in connection with any dissemination of this information in accordance with this section.

(5) Health care facilities must send and receive the background check information in a manner that reasonably protects the subject's rights to privacy and confidentiality.

(6) In accordance with RCW 74.39A.210, a home that discloses information about a former or current employee to certain types of prospective employers is presumed to act in good faith and is immune from civil and criminal liability for such disclosure or its consequences.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10174, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10174, filed 1/12/09, effective 2/12/09.]

WAC 388-76-10175 Background check employment—Conditional hire—Pending results. An adult family home may conditionally employ a person directly or by contract, pending the result of a background check, provided the home:

(1) Requests the background check no later than one business day after conditional employment;

(2) Requires the individual to sign a disclosure statement and the individual denies having been convicted of a disqualifying crime or a disqualifying finding under WAC 388-76-10180;

(3) Does not allow the individual to have unsupervised access to any resident;

(4) Ensures direct supervision, of the individual, as defined in WAC 388-76-10000; and

(5) Ensures the individual is competent and receives the necessary training to perform assigned tasks and meets the staff training requirements under chapter 388-112 WAC.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10175, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10175, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10180 Background check—Employment—Disqualifying information. Unless hired conditionally as specified in WAC 388-76-10175, the adult family home must not use or employ anyone, directly or by contract, who is listed in WAC 388-76-10161 if the individual has:

(1) Any of the convictions, history, or findings, described below:

(a) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults;

(b) Has been convicted of a crime in federal court or in any other state, and the department determines that the crime is equivalent to a crime under subsections (c), (d), (e), (f), or (g) below;

(c) Has been convicted of a "crime against children or other persons" as defined in RCW 43.43.830, unless the crime is simple assault, assault in the fourth degree, or prostitution and more than three years has passed since conviction;

(d) Has been convicted of "crimes relating to financial exploitation" as defined in RCW 43.43.830, unless the crime is theft in third degree and more than three years have passed since conviction, or unless the crime is forgery or theft in the second degree and more than five years has passed since conviction;

(e) Has been convicted of:

(i) Violation of the Imitation Controlled Substances Act (VICSA);

(ii) Violation of the Uniform Controlled Substances Act (VUCSA);

(iii) Violation of the Uniform Legend Drug Act (VULDA); or

(iv) Violation of the Uniform Precursor Drug Act (VUPDA).

(f) Has been convicted of sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;

(g) Has been convicted of criminal mistreatment;

(h) Has been found to have abused, neglected, financially exploited, or abandoned a minor or vulnerable adult by court of law or a disciplining authority, including the department of health. Examples of legal proceedings in which such findings could be made include juvenile court proceedings under chapter 13.34 RCW, domestic relations proceeding under Title 26, RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW;

(i) Has a finding of abuse or neglect of a child that is:

(i) Listed on the department's background check central unit (BCCU) report; or

(ii) Disclosed by the individual, except for findings made before December, 1998.

(j) Has a finding of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult that is:

(i) Listed on any registry, including the department's registry;

(ii) Listed on the department's background check central unit (BCCU) report; or

(iii) Disclosed by the individual, except for adult protective services findings made before October, 2003.

(2) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the adult family home.

[Statutory Authority: RCW 70.128.040, chapter 74.39A RCW. 10-16-082, § 388-76-10180, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10180, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10180, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10191 Liability insurance required. The adult family home must:

(1) Obtain liability insurance upon licensure and maintain the insurance as required in WAC 388-76-10192 and 388-76-10193; and

(2) Have evidence of liability insurance coverage available if requested by the department.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10191, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10192 Liability insurance required—Commercial general liability insurance or business liability insurance coverage. The adult family home must have commercial general liability insurance or business liability insurance that includes:

(1) Coverage for the acts and omissions of any employee and volunteer;

(2) Coverage for bodily injury, property damage, and contractual liability;

(3) Coverage for premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract; and

(4) Minimum limits of:

(a) Each occurrence at five hundred thousand dollars; and

(b) General aggregate at one million dollars.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10192, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10193 Liability insurance required—Professional liability insurance coverage. The adult family home must have professional liability insurance or errors and omissions insurance if the adult family home licensee has a professional license, or employs professionally licensed staff. The insurance must include:

(1) Coverage for losses caused by errors and omissions of the adult family home, its employees, and volunteers; and

(2) Minimum limits of:

(a) Each occurrence at five hundred thousand dollars; and

(b) Aggregate at one million dollars.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10193, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10195 Adult family home—Staff—Generally. The adult family home must ensure:

(1) When one or more residents are in the home, enough staff are available in the home to meet the needs of each resident, except as provided in WAC 388-76-10200;

(2) Staff are readily available to meet resident needs if the home takes the resident out to another location and the resident negotiated care plan does not indicate it is safe for the resident to be left unattended for a specific time period; and

(3) All staff are skilled and able to do the tasks assigned to meet the needs of each resident.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10195, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10195, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10198 Adult family home—Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(1) Staff information such as address and contact information.

(2) Staff orientation and training records pertinent to duties, including, but not limited to:

(a) Training required by chapter 388-112 WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;

(b) Cardiopulmonary resuscitation;

(c) First aid; and

(d) HIV/AIDS training.

(3) Tuberculosis testing results.

(4) Criminal history disclosure and background check results as required.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10198, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10200 Adult family home—Staff—Availability—Contact information. In addition to other licensing requirements for staff availability, the adult family home must:

(1) Ensure at least one caregiver is present in the home whenever one or more residents are present in the home, unless the resident has been assessed as being safe when left unattended for a specific period of time, and that information is included in the negotiated care plan;

(2) Designate an experienced, staff member who is capable of responding on behalf of the adult family home by phone or pager at all times.

(3) Give residents the telephone or pager number for the contact required in subsection (2) of this section;

(4) Ensure the provider, entity representative or resident manager is readily available to:

(a) Each resident;

(b) Residents' representatives;

(c) Caregivers; and

(d) Authorized state staff.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10200, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10200, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10225 Reporting requirement. (1) The adult family home must ensure all staff:

(a) Report suspected abuse, neglect, exploitation or abandonment of a resident:

(i) As required by chapter 74.34 RCW;

(ii) To the department by calling the complaint toll-free hotline number; and

(iii) To the local law enforcement agency when required by RCW 74.34.035.

(b) Report the following to the department by calling the complaint toll-free hotline number:

(i) Any actual or potential event requiring any resident to be evacuated;

(ii) Conditions that threaten the provider's or entity representative's ability to continue to provide care or services to each resident; and

(iii) A missing resident.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

(b) The resident's representative, if one exists;

(c) The resident's health care provider;

(d) Other appropriate professionals working with the resident;

(e) Persons identified in the negotiated care plan; and

(f) The resident's case manager if the resident is a department client.

(3) Whenever an outbreak of suspected food poisoning or communicable disease occurs, the adult family home must notify:

(a) The local public health officer; and

(b) The department's complaint toll-free hotline number.

(4) The adult family home must notify the department's case management office within twenty-four hours whenever a resident, whose stay is paid for by the department is discharged for more than twenty-four hours on medical leave to a nursing home or hospital.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10225, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10225, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10270 Tuberculosis—Testing method—Required. The adult family home must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

(b) By a trained professional; or

(2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10270, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10270, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10275 Tuberculosis—No testing. The adult family home is not required to have a person tested for tuberculosis if the person has:

(1) A documented history of a previous positive skin test, with ten or more millimeters induration;

(2) A documented history of a previous positive blood test; or

(3) Documented evidence of:

(a) Adequate therapy for active disease; or

(b) Completion of treatment for latent tuberculosis infection preventive therapy.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10275, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10275, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10280 Tuberculosis—One test. The adult family home is only required to have a person take one test if the person has any of the following:

(1) A documented history of a negative result from a previous two step test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10280, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10280, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10285 Tuberculosis—Two step skin testing. Unless the person meets the requirement for having no skin testing or only one test, the adult family home, choosing to do skin testing, must ensure that each person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10285, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10285, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10290 Tuberculosis—Positive test result. When there is a positive result to tuberculosis skin or blood testing the adult family home must:

(1) Ensure that the person has a chest X ray within seven days;

(2) Ensure each resident or employee with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the person's health care provider.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10290, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10290, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10295 Tuberculosis—Negative test result. The adult family home may be required by the public health provider or licensing authority to ensure that persons with negative test results have follow-up testing in certain circumstances, such as:

(1) After exposure to active tuberculosis;

(2) When tuberculosis symptoms are present; or

(3) For periodic testing as determined by the health provider.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10295, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10295, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10300 Tuberculosis—Declining a skin test. The adult family home must ensure that a person take the blood test for tuberculosis if they decline the skin test.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10300, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10300, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10305 Tuberculosis—Reporting required. The adult family home must:

(1) Report any person or resident with tuberculosis symptoms or a positive chest X ray to the appropriate health care provider or public health provider;

(2) Follow the infection control and safety measures ordered by the person's health care provider, including a public health provider; and

(3) Institute appropriate infection control measures.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10305, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10305, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10310 Tuberculosis—Test records. The adult family home must:

(1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the adult family home;

(2) Make the records readily available to the appropriate health authority and licensing agency;

(3) Provide the employee a copy of his/her testing results; and

(4) Retain the records for eighteen months after the date an employee either quits or is terminated.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10310, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10310, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10415 Food services. The adult family home must:

(1) Ensure that the safe food handling training requirements of chapter 388-112 WAC are met; and

(2) Serve meals:

(a) In the home where each resident lives; and

(b) That accommodate each resident's:

(i) Preferences;

(ii) Food allergies and sensitivities;

(iii) Caloric needs;

(iv) Cultural and ethnic background; and

(v) Physical condition that may make food intake difficult such as being hard for the resident to chew or swallow.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10415, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10415, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10420 Meals and snacks. The adult family home must:

(1) Serve at least three meals:

(a) In each twenty-four hour period;

(b) At regular times comparable to normal meal times in the community; and

(c) That meet the nutritional needs of each resident.

(2) Make nutritious snacks available to residents:

(a) Between meals; and

(b) In the evening.

(3) Get input from residents in meal planning and scheduling;

(4) Serve nutrient concentrates, supplements, and modified diets only with written approval of the resident's physician;

(5) Only serve pasteurized milk;

(6) Process any home-canned foods served in the home, according to the latest guidelines of the county cooperative extension service; and

(7) Ensure food is:

(a) In sufficient supply; and

(b) Safe, sanitary, and uncontaminated.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10420, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10420, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10455 Medication—Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(1) Performed by a practitioner as defined in chapter 69.41 RCW; or

(2) By nurse delegation per WAC 246-840-910 through 246-840-970; unless

(3) Done by a family member or legally appointed resident representative.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10455, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10455, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10490 Medication disposal—Written policy—Required. The adult family home must have and implement a written policy addressing the disposal of unused or expired resident medications. Unused and expired medication must be disposed of in a safe manner for:

(1) Current residents living in the adult family home; and

(2) Residents who have left the home.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10490, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10490, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10505 Specialty care—Admitting and retaining residents. The adult family home must not admit or keep a resident with specialty care needs, such as developmental disability, mental illness, or dementia as defined in WAC 388-76-10000, if the provider, entity representative, resident manager and staff have not completed the specialty care training required by chapter 388-112 WAC.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10505, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10505, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10520 Resident rights—General notice. The adult family home must:

(1) Inform each resident both orally and in writing in a language the resident understands of resident rights, including rights under chapter 70.129 RCW and all rules and regulations governing resident conduct and responsibilities during the stay in the home;

(2) Ask the resident to sign and date they received the information; and

(3) Provide a statement indicating whether the adult family home will accept medicaid or other public funds as a source of payment for services.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10520, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10520, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10522 Resident rights—Notice—Policy on accepting medicaid as a payment source. The adult family home must fully disclose the home's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the adult family home provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10522, filed 1/15/10, effective 2/15/10.]

WAC 388-76-10540 Resident rights—Disclosure of fees and notice requirements—Deposits. (1) Before admission, if the adult family home requires payment of an admissions fee, deposit, or a minimum stay fee, by or on behalf of a person seeking admission, the home must give the resident full disclosure in writing in a language the resident understands.

(2) The disclosure must include:

(a) A statement of the amount of any admissions fees, deposits, prepaid charges, or minimum stay fees;

(b) The home's advance notice or transfer requirements; and

(c) The amount of the deposits, admission fees, prepaid charges, or minimum stay fees that will be refunded to the resident if the resident leaves the home.

(3) The home must ensure that the receipt of the disclosures required under subsection (1) of this section is in writing and signed and dated by the resident and the home.

(4) If the home does not provide these disclosures, the home must not keep the deposits, admission fees, prepaid charges, or minimum stay fees.

(5) If a resident dies, is hospitalized or is transferred to another facility for more appropriate care and does not return to the home, the adult family home:

(a) Must refund any deposit or charges already paid less the home's per diem rate for the days the resident actually resided, reserved or retained a bed in the home in spite of any minimum stay policy or discharge notice requirements; except that

(b) May keep an additional amount to cover its reasonable and actual expenses incurred as a result of a private-pay resident's move, not to exceed five days per diem charges; unless the resident has given advance notice in compliance with the admission agreement.

(6) All adult family homes covered under this section are required to refund any and all refunds due the resident within thirty days from the resident's date of discharge from the home.

(7) Nothing in this section applies to provisions in contracts negotiated between a home and a certified health plan, health or disability insurer, health maintenance organization, managed care organization, or similar entities.

(8) If the home requires an admission agreement by or on behalf of an individual seeking admission the home must ensure the terms of the agreement are consistent with the requirements of this section, chapters 70.128, 70.129 and 74.34 RCW, and other applicable state and federal laws.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10540, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10540, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10550 Resident rights—Adult family home staffing—Notification required. The adult family home must provide the following information to prospective residents and current residents:

(1) Information about the provider, entity representative and resident manager, if there is a resident manager:

(a) Availability in the home, including a general statement about how often he or she is in the home;

(b) Education and training relevant to resident caregiving;

(c) Caregiving experience;

(d) His or her primary responsibilities, including whether he or she makes daily general care management decisions; and

(e) How to contact the provider, entity representative or resident manager when he or she is not in the home.

(2) Information about a licensed practical nurse or registered nurse, if there is one, who is in any way involved in the care of residents:

(a) Who the licensed practical nurse or registered nurse is employed by;

(b) The specific routine hours that the licensed practical nurse or registered nurse is on-site, if they are on-site routinely;

(c) His or her primary responsibilities, including whether he or she makes daily general care management decisions;

(d) The nonroutine times when the licensed practical nurse or registered nurse will be available, such as on-call; and

(e) A description of what the provider or entity representative will do to make available the services of a licensed nurse in an emergency or change in a resident's condition.

(3) A statement indicating whether the provider, caregiver or staff is qualified or willing to become qualified to perform nurse delegation as allowed under state law.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10550, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10550, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10584 Resident rights—Examination of license. The adult family home must place its license to operate and any conditions on the license, in a visible location in a common use area where it can be examined by residents, resident representatives, the department and anyone interested without having to ask for them.

[Statutory Authority: RCW 70.128.040. 10-14-058, § 388-76-10584, filed 6/30/10, effective 7/31/10.]

WAC 388-76-10585 Resident rights—Examination of inspection results. (1) The adult family home must place the following documents in a visible location in a common use area where they can be examined by residents, resident representatives, the department and anyone interested without having to ask for them.

(a) A copy of the most recent inspection report and related cover letter; and

(b) A copy of all complaint investigation reports, and any related cover letters received since the most recent inspection or not less than the last twelve months.

(2) The adult family home must post a notice that the following documents are available for review if requested by the residents, resident representatives, the department and anyone interested.

(a) A copy of each inspection report and related cover letter received during the past three years; and

(b) A copy of any complaint investigation reports and related cover letters received during the past three years.

[Statutory Authority: RCW 70.128.040. 10-14-058, § 388-76-10585, filed 6/30/10, effective 7/31/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10585, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10673 Abuse and neglect reporting—Mandated reporting to department—Required. (1) In accordance with chapter 74.34 RCW, all providers, entity representatives, resident managers, owners, caregivers, staff, and students that provide care and services to residents, are mandated reporters and must immediately report to the department when there is:

(a) A reasonable cause to believe that abandonment, abuse, exploitation, financial exploitation, or neglect of a vulnerable adult has occurred; or

(b) A reason to suspect that sexual assault of a vulnerable adult has occurred.

(2) Reports must be made to:

(a) The centralized toll free telephone number provided by the department; and

(b) The appropriate law enforcement agencies, as required under chapter 74.34 RCW.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10673, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-10673, filed 2/15/08, effective 3/17/08.]

WAC 388-76-10685 Bedrooms. The adult family home must:

(1) Ensure each resident's bedroom is an outside room, which allows entrance of natural light;

(2) Ensure window and door screens:

(a) Do not hinder emergency escape; and

(b) Prevent entrance of flies and other insects.

(3) Ensure each resident, including those using mobility aids such as wheelchairs and walkers has direct, unrestricted, and free access from the bedroom through doors, hallways and corridors to common use areas and other rooms used for care and services including bathrooms;

(4) Make separate bedrooms available for each sex;

(5) Make reasonable efforts to accommodate residents wanting to share the room;

(6) Provide each bedroom with a minimum usable floor space as required in WAC 388-76-10690.

(7) Ensure each bedroom has a closet or a wardrobe, armoire or reasonable facsimile thereof. Neither the closet nor wardrobe/armoire floor space will be considered a part of the room's usable square footage. The home must not remove a closet in order to provide additional floor space.

(8) Ensure no more than two residents to a bedroom;

(9) Unless the resident chooses to provide their own furniture and bedding, the home must provide each resident a bed thirty-six inches or more wide with:

(a) A clean, comfortable mattress;

(b) A waterproof cover for use when needed or requested by the resident;

(c) Clean sheets and pillow cases;

(d) Adequate clean blankets to meet the needs of each resident; and

(e) Clean pillows.

(10) Not use the upper bunk of double-deck beds for a resident's bed;

(11) Provide a call bell or intercom system if the provider, entity representative, resident manager or caregiver bedroom is not within hearing distance of each resident bedroom and the system is required by the department;

(12) Ensure that members of the household, other than residents, do not share bedrooms with residents; and

(13) Ensure a resident does not share a bedroom with a person under eighteen years of age, unless the person is the resident's own child.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10685, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10685, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10750 Safety and maintenance. The adult family home must:

(1) Keep the home both internally and externally in good repair and condition with a safe, comfortable, sanitary, homelike environment that is free of hazards;

(2) Ensure that there is existing outdoor space that is safe and usable for residents;

(3) Provide clean, functioning, safe, adequate household items and furnishings to meet the needs of each resident;

(4) Provide safe and functioning systems for:

(a) Heating;

(b) Cooling, which may include air circulating fans;

(c) Hot and cold water;

(d) Electricity;

(e) Plumbing;
(f) Garbage disposal;
(g) Sewage;
(h) Cooking;
(i) Laundry;
(j) Artificial and natural light;
(k) Ventilation; and
(l) Any other feature of the home.

(5) Ensure water temperature does not exceed one hundred twenty degrees Fahrenheit at all fixtures used by or accessible to residents, such as:
(a) Tubs;
(b) Showers; and
(c) Sinks.

(6) Provide storage for toxic substances, poisons, and other hazardous materials that is only accessible to residents under direct supervision, unless the resident is assessed for and the negotiated care plan indicates it is safe for the resident to use the materials unsupervised;

(7) Provide rapid access for all staff to any bedroom, toilet room, shower room, closet, other room occupied by each resident;

(8) Keep all firearms locked and accessible only to authorized persons; and

(9) Keep the home free from:
(a) Rodents;
(b) Flies;
(c) Cockroaches, and
(d) Other vermin.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10750, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10750, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10820 Resident evacuation capabilities and location of resident bedrooms. (1) The adult family home must ensure each resident who requires assistance for evacuation has a bedroom located on ground level floor and can exit the home without use of:
(a) Stairs;
(b) Elevator;
(c) Chairlift; or
(d) Platform lift.

(2) The home must install alternative emergency evacuation protection equipment when serving hearing or visually impaired residents.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10820, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10820, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10840 Emergency food supply. The adult family home must have an on-site emergency food supply that can be stored with other food in the home and that:

(1) Will last for a minimum of seventy-two hours for each resident and each household member;

(2) Meets the dietary needs of each resident, including any specific dietary restrictions any resident may have; and

(3) Is sufficient, safe, sanitary, and uncontaminated.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10840, filed 1/15/10, effective 2/15/10; 09-03-029, § 388-76-10840, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10840, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10845 Emergency drinking water supply. The adult family home must have an on-site emergency supply of drinking water that:

(1) Will last for a minimum of seventy-two hours for each resident and each household member;

(2) Is at least three gallons for each resident and each household member;

(3) Is stored in well sealed food grade or glass containers;

(4) Is chlorinated or commercially bottled;

(5) Is replaced every six months unless the commercial water bottle is labeled for a longer expiration date; and

(6) Is stored in a cool, dry location away from direct sunlight.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10845, filed 1/15/10, effective 2/15/10; 09-03-029, § 388-76-10845, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10845, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10860 Fire drill plan and procedures for emergency evacuation—Required. The adult family home must:

(1) Have an emergency evacuation plan, including a fire drill plan and procedures for evacuating all residents from the adult family home; and

(2) Not admit or keep residents who cannot safely be evacuated.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10860, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10860, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10870 Resident evacuation capability levels—Identification required. The adult family home must ensure that each resident's assessment identifies, and each resident's preliminary care plan and negotiated care plan describes the resident's ability to evacuate the home according to the following descriptions:

(1) Independent: Resident is physically and mentally capable of safely getting out of the home without the assistance of another individual or the use of mobility aids. The department will consider a resident independent if capable of getting out of the home after one verbal cue;

(2) Assistance required: Resident is not physically or mentally capable of getting out of the house without assistance from another individual or mobility aids.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10870, filed 1/15/10, effective 2/15/10; 09-03-029, § 388-76-10870, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10870, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10880 Emergency evacuation adult family home bedrooms. The adult family home must ensure each resident with an evacuation capability of "assistance required" has a bedroom on a ground-level floor which:

(1) Has at least one means of exiting the floor where the bedroom is located; to the outdoors, without going through any room including the garage; and

(2) Exiting from the bedroom does not require the use of:

(a) Stairs;
(b) Elevators;
(c) Chairlift; or
(d) A platform lift.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10880, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10880, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10920 Inspection and investigation reports—Provided by department. The department will mail or hand deliver the department's report to the adult family home:

(1) Within ten working days of completion of the inspection process; or

(2) Within ten calendar days of completion of the inspection if the home does not have a deficiency.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10920, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10920, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10955 Remedies—Department must impose remedies. (1) The department must impose a remedy or remedies if the department substantiates a complaint involving harm to a resident and violation of an applicable law or rule.

(2) The department must impose a remedy or remedies if the department substantiates, after licensure, that it has been less than twenty years since the adult family home voluntarily surrendered or relinquished an adult family home license in lieu of department initiated denial, suspension, nonrenewal, or revocation of a license.

(3) The department must impose a remedy or remedies if the department finds any person listed in WAC 388-76-10950:

(a) Has a history of significant noncompliance with federal or state laws or regulations in the provision of care or services to children or vulnerable adults;

(b) Has been convicted of a "crime against children or other persons" as defined in RCW 43.43.830, unless the crime is simple assault, assault in the fourth degree, or prostitution and more than three years has passed since conviction;

(c) Has been convicted of "crimes relating to financial exploitation" as defined in RCW 43.43.830, unless the crime is theft in third degree and more than three years have passed since conviction, or unless the crime is forgery or theft in the second degree and more than five years has passed since conviction;

(d) Has been convicted of:

(i) Violation of the Imitation Controlled Substances Act (VICSA);

(ii) Violation of the Uniform Controlled Substances Act (VUCSA);

(iii) Violation of the Uniform Legend Drug Act (VULDA); or

(iv) Violation of the Uniform Precursor Drug Act (VUPDA).

(e) Has been convicted of sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;

(f) Has been convicted of criminal mistreatment;

(g) Has been found to have abused, neglected, financially exploited, or abandoned a minor or vulnerable adult by court of law or a disciplining authority, including the department of health. Examples of legal proceedings in which such findings could be made include juvenile court proceedings under chapter 13.34 RCW, domestic relations proceedings under Title 26 RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW.

(h) Has a finding of abuse or neglect of a child that is:

(i) Listed on the department's background check central unit (BCCU) report; or

(ii) Disclosed by the individual, except for findings made before December, 1998.

(i) Has a finding of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult that is:

(i) Listed on any registry, including the department's registry;

(ii) Listed on the department's background check central unit (BCCU) report; or

(iii) Disclosed by the individual, except for adult protective services findings made before October, 2003.

(j) Has been convicted of a crime in federal court or in the court of any other state, and the department determines that the conviction is equivalent to a conviction under subsection (3)(b), (c), (d), (e) or (f) above.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10955, filed 1/15/10, effective 2/15/10; 09-03-028, § 388-76-10955, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10955, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10960 Remedies—Department may impose remedies. The department may impose a remedy or remedies if the department finds any person listed in WAC 388-76-10950:

(1) Has been convicted of:

(a) Any felony that the department determines is reasonably related to the competency of the person to be involved in the ownership or operation of an adult family home; or

(b) A crime involving a firearm used in the commission of a felony or in any act of violence against a person.

(2) Has engaged in the illegal use, sale or distribution of drugs or excessive use of alcohol or drugs without the evidence of rehabilitation;

(3) Has committed an act of domestic violence toward a family or household member;

(4) Has been found in any final decision of a federal or state agency to have abandoned, neglected, abused, or financially exploited a vulnerable adult, unless such decision requires imposition of a remedy under WAC 388-76-10955;

(5) Has had a license for the care of children or vulnerable adults denied, suspended, revoked, or not renewed;

(6) Has a history of violations of chapter 70.128 RCW, or any law regulating residential care facilities, that resulted in revocation, suspension, or nonrenewal of a license with the department;

(7) Has been enjoined from operating a facility for the care and services of children or adults;

(8) Has had a medicaid or medicare provider agreement or any other contract for the care and treatment of children or vulnerable adults, terminated, cancelled, suspended, or not

renewed by any public agency, including a state medicaid agency;

(9) Has been the subject of a sanction, corrective, or remedial action taken by federal, state, county, or municipal officials or safety officials related to the care or treatment of children or vulnerable adults;

(10) Has obtained or attempted to obtain a license by fraudulent means or misrepresentation;

(11) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a license or any data attached to the application, or in any matter involving the department;

(12) Permitted, aided, or abetted the commission of any illegal act on the adult family home premises;

(13) Willfully prevented, interfered with, or failed to cooperate with any inspection, investigation, or monitoring visit made by the department, including refusal to permit authorized department representatives to interview residents or have access to their records;

(14) Failed or refused to comply with:

(a) A condition imposed on a license or a stop placement order; or

(b) The requirements of chapters 70.128, 70.129, 74.34 RCW, this chapter or any other applicable laws.

(15) Misappropriated property of a resident, unless such action requires a remedy under WAC 388-76-10955;

(16) Exceeded licensed capacity in the operation of an adult family home;

(17) Operated a facility for the care of children or adults without a license or with a revoked license;

(18) In connection with the operation of any facility for the care of children or adults, relinquished or returned a license, or did not seek license renewal following written notification that the licensing agency intends to deny, suspend, cancel or revoke the license, unless such action requires imposition of a remedy under WAC 388-76-10955;

(19) When providing care to children or vulnerable adults, has had resident trust funds or assets seized by the Internal Revenue Service or a state entity for failure to pay income or payroll taxes;

(20) Failed to meet financial obligations as the obligations fell due in the normal course of owning or operating a business involved in the provision of care and services to children or vulnerable adults;

(21) Has failed to meet personal financial obligations and that failure has resulted in a failure to provide necessary care and services to the residents;

(22) Interfered with a long-term care ombudsman or department staff in the performance of his or her duties; or

(23) Failed to relinquish or surrender the license as required.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10960, filed 1/15/10, effective 2/15/10; 09-03-028, § 388-76-10960, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10960, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10970 Remedies—Specific—Condition(s) on license. (1) The department may impose reasonable conditions or limits on a new or current license.

(2) Conditions or limits the department may impose on a license include, but are not limited to, the following:

(a) Correction of deficiencies within a specified time;

(b) Training related to the deficiencies;

(c) Limits on the type of residents the adult family home may admit or serve;

(d) Discharge of any resident when the department finds discharge is needed to meet that resident's needs or for the protection of other residents;

(e) Change in license capacity;

(f) Removal of the adult family home's designation as a specialized home;

(g) Prohibition of access to residents by a specified person; and

(h) Demonstration of ability to meet financial obligations necessary to continue operation.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10970, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10970, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10975 Remedies—Specific—Civil penalties. (1) The department may impose civil penalties of not more than one hundred dollars per day per violation except that:

(a) Fines up to one thousand dollars can be issued under RCW 70.128.150 for willful interference with a representative of the long-term care ombudsman; and

(b) Fines up to three thousand dollars can be issued under RCW 74.39A.060 for retaliation against a resident, employee, or any other person making a complaint, providing information to, or cooperating with, the ombudsman, the department, the attorney's general office, or a law enforcement agency.

(2) When the adult family home fails to pay a fine under this chapter when due, the department may, in addition to other remedies, withhold an amount equal to the fine plus interest, if any, from any contract payment due to the provider from the department.

(3) Civil monetary penalties are due twenty-eight days after the adult family home or the owner or operator of an unlicensed adult family home is served with notice of the penalty unless the adult family home requests a hearing in compliance with chapter 34.05 RCW, RCW 43.20A.215, and this chapter. If the hearing is requested, the penalty becomes due ten days after a final decision in the department's favor is issued. Thirty days after the department serves the adult family home with notice of the penalty, interest begins to accrue at a rate of one percent per month as authorized by RCW 43.20B.695.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10975, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10975, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10985 Remedies—May extend to multiple homes. (1) If a licensed provider also operates an unlicensed adult family home, the department may impose a remedy or remedies listed in WAC 388-76-10940 on the licensed adult family home or homes.

(2) If violations in an adult family home are of such nature as to present a serious risk or harm to residents of other

homes operated by the same provider, the department may impose remedies on those other homes.

[Statutory Authority: RCW 70.128.040. 10-04-008, § 388-76-10985, filed 1/22/10, effective 2/22/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10985, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10990 Informal dispute resolution (IDR). (1) When an adult family home disagrees with the department's finding of a violation under this chapter, the adult family home has the right to have the violation reviewed by the department under the department's dispute resolution process.

(2) The purpose of the review is to give the adult family home an opportunity to present information that might warrant modification or deletion of a finding of a violation.

(3) The adult family home may submit a written statement for review.

(4) In addition to a written statement, the adult family home may ask to present the information in person to a department designee.

(5) Requests for review must be made in writing to the department at the address provided in the department's certified notice within ten working days of receipt of the written finding of a violation.

(6) Orders of the department imposing license suspension, stop placement, or conditions on a license are effective immediately upon notice and shall continue pending dispute resolution.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10990, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10990, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10995 Notice, hearing rights, and effective dates relating to imposition of remedies. (1) Chapter 34.05 RCW applies to department actions under this chapter and chapter 70.128 RCW, except that orders of the department imposing license suspension, stop placement, or conditions on license are effective immediately upon notice and must continue pending a final administrative decision.

(2) An adult family home contesting the imposition of any remedy by the department must within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt to the agency at the mailing address contained in the department's notice imposing the remedy; and

(b) Include in or with the application:

(i) The reasons for contesting the department decision; and

(ii) A copy of the contested department decision.

(3) Administrative proceedings are governed by chapter 34.05 RCW, RCW 43.20A.215, where applicable, this section, and chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter applies.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-10995, filed 1/15/10, effective 2/15/10; 09-03-029, § 388-76-10995, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10995, filed 10/16/07, effective 1/1/08.]

WAC 388-76-11004 Resident protection program—Individual defined. As used in WAC 388-76-11005 through 388-76-11040, the term "individual" means anyone used by the adult family home to provide services to residents who is alleged to have abandoned, abused, neglected, or financially exploited a resident. "Individual" includes, but is not limited to employees, contractors, and volunteers.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11004, filed 1/15/10, effective 2/15/10.]

WAC 388-76-11005 Resident protection program—Notice to individual of preliminary finding. (1) The department will serve notice of the preliminary finding as provided in WAC 388-76-11080.

(2) The department may establish proof of service as provided in WAC 388-76-11085.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11005, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-11005, filed 2/15/08, effective 3/17/08.]

WAC 388-76-11010 Resident protection program—Notice to others of preliminary finding. Consistent with confidentiality requirements concerning the resident, witnesses, and reporter, the department may provide notification of a preliminary finding to:

(1) Other divisions within the department;

(2) The agency or program identified under RCW 74.34.068 with which the individual was associated as an employee, volunteer or contractor;

(3) The employer or program that is currently associated with the individual, if known;

(4) Law enforcement;

(5) Other entities as authorized by law and this chapter including investigative authorities consistent with chapter 74.34 RCW; and

(6) The appropriate licensing agency.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11010, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-11010, filed 2/15/08, effective 3/17/08.]

WAC 388-76-11015 Resident protection program—Disputing a preliminary finding. (1) The individual may request an administrative hearing to challenge a preliminary finding made by the department.

(2) The request must be made in writing to the office of administrative hearings.

(3) The office of administrative hearings must receive the individual's written request for an administrative hearing within thirty calendar days of the date written on the notice of the preliminary finding.

(4) The written request for a hearing must include the individual's full legal name and current mailing address and should include:

(a) The individual's telephone number;

(b) A brief explanation of why the individual disagrees with the preliminary finding;

(c) A description of any assistance needed in the administrative appeal process by the individual, including a foreign

or sign language interpreter or any reasonable accommodation for a disability; and

(d) The individual's signature.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11015, filed 1/15/10, effective 2/15/10; 09-03-030, § 388-76-11015, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-11015, filed 2/15/08, effective 3/17/08.]

WAC 388-76-11025 Resident protection program—Finalizing a preliminary finding. (1) A preliminary finding becomes a final finding when:

(a) The department notifies the individual there is a preliminary finding under WAC 388-76-11005; and

(b) The individual does not ask for an administrative hearing; or

(c) The administrative law judge:

(i) Dismisses the appeal following withdrawal of the appeal or default; or

(ii) Dismisses the appeal for failure to comply with the time limits under WAC 388-76-11015; or

(iii) Issues an initial order upholding the finding and the individual fails to appeal the initial order to the department's board of appeals; or

(d) The board of appeals issues a final order upholding the finding.

(2) A final finding is permanent.

(3) A final finding will only be removed from the department or agency list of individuals found to have abandoned, abused, neglected, exploited, or financially exploited a vulnerable adult if it is rescinded following judicial review.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11025, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-11025, filed 2/15/08, effective 3/17/08.]

WAC 388-76-11030 Resident protection program—Appeal of the initial order or finding. (1) If the individual or the department disagrees with the administrative law judge's decision, either party may challenge this decision by filing a petition for review with the department's board of appeals under chapter 34.05 RCW, Administrative Procedure Act, and chapter 388-02 WAC.

(2) If the department appeals the administrative law judge's decision, the department will not change the finding in the department's records until a final hearing decision is issued.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11030, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-11030, filed 2/15/08, effective 3/17/08.]

WAC 388-76-11035 Resident protection program—Reporting final findings. The department will report a final finding of abandonment, abuse, neglect, exploitation, or financial exploitation within ten working days to the following:

(1) The individual for whom there is a final finding;

(2) The adult family home that was associated with the individual during the time of the incident;

(3) The adult family home or program that is currently associated with the individual, if known;

(4) The appropriate licensing, certification or registration authority;

(5) Any federal or state registry or list of individuals found to have abandoned, abused, neglected, exploited, or financially exploited a vulnerable adult; and

(6) The findings may be disclosed to the public upon request subject to applicable public disclosure laws.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11035, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-11035, filed 2/15/08, effective 3/17/08.]

WAC 388-76-11040 Resident protection program—Disclosure of investigative and finding information. (1) Confidential information about residents and mandated reporters received from the department may only be used by the individual to challenge findings through the appeals process. It may only be shared with persons who are involved in the appeal.

(2) Confidential information such as the name and other personal identifying information of the reporter, witnesses, or the resident will be redacted from documents unless release of that information is consistent with chapter 74.34 RCW and other applicable state and federal laws.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11040, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 08-05-098, § 388-76-11040, filed 2/15/08, effective 3/17/08.]

WAC 388-76-11050 Management agreements—General. As used in WAC 388-76-11050 through 388-76-11070, the term "manager" means the individual or entity providing management services under a management agreement. It does not mean a resident manager.

(1) If the adult family home uses a manager, the adult family home must have a written management agreement approved by the department that is consistent with chapter 388-76 WAC requirements.

(2) The adult family home must notify the department of its use of a manager when:

(a) Entering into a management agreement following initial application;

(b) Changing managers; or

(c) Modifying an existing management agreement.

(3) An applicant must notify the department of its use of a manager when:

(a) Applying for an adult family home license; or

(b) Entering into a management agreement prior to licensure.

(4) The adult family home must submit the written management agreement, including an organizational chart which shows the relationship between the adult family home, management company, and all related entities, including management staff.

(5) The written management agreement must be submitted:

(a) With the initial license, change of ownership, or change of location applications; and

(b) Sixty days prior to the proposed change of ownership date or the effective date of the management agreement.

(6) The adult family home must submit any amendment to an existing management agreement to the department thirty days before the amendment takes effect.

(7) The adult family home must notify current residents and their representatives sixty days before entering into a management agreement.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11050, filed 1/15/10, effective 2/15/10.]

WAC 388-76-11055 Management agreements—Adult family home. (1) The adult family home is responsible for:

(a) The daily operations and provision of care and services to residents;

(b) Compliance with all applicable laws and rules;

(c) Ensuring the manager complies with the department approved management agreement; and

(d) Ensuring the manager does not represent itself as, or give the appearance that it is the provider.

(2) The adult family home must not give the manager responsibilities that are so extensive the adult family home is relieved of responsibility for the daily operations and provision of care and services to residents. If the adult family home relinquishes responsibility for daily operation and provision of care and services to residents, the department will determine that a change of ownership has occurred.

(3) The adult family home and manager must act in accordance with the terms of the department approved management agreement. If the department determines they are not, then the department may take licensing action.

(4) The adult family home may enter into a management agreement only if the management agreement creates a principal/agent relationship between the adult family home and manager.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11055, filed 1/15/10, effective 2/15/10.]

WAC 388-76-11060 Terms of the management agreement. Management agreements, at a minimum must:

(1) Describe the responsibilities of the adult family home and manager, including items, services, and activities to be provided;

(2) Maintain and retain all records in accordance with this chapter;

(3) Allow the department unlimited access to documentation and records according to applicable laws or regulations;

(4) Require the manager to immediately send copies of inspections and notices of noncompliance to the adult family home;

(5) Require the adult family home's governing body, board of directors or similar authority to appoint the entity representative;

(6) Require the adult family home to participate in monthly oversight meetings and at minimum, quarterly on-site visits to the home;

(7) State that the adult family home is responsible for reviewing, acknowledging and signing all initial, change of ownership, and change of location license applications;

(8) State that the adult family home and manager will review the management agreement annually and notify the department of change according to applicable regulations;

(9) Acknowledge that the adult family home is the party ultimately responsible for complying with all applicable laws and rules;

(10) Require the adult family home to oversee and maintain ultimate responsibility for:

(a) All personnel issues relating to the operation of the home;

(b) The care, services, and safety of all residents; and

(c) Staffing plans, staff, volunteer and student orientation and training;

(11) State the manager will not represent itself or give the appearance it is the provider;

(12) State that a duly authorized manager may execute resident leases or agreements on behalf of the adult family home, however all such resident leases or agreements must be between the adult family home and the resident or the resident's representative.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11060, filed 1/15/10, effective 2/15/10.]

WAC 388-76-11065 Management agreements—Department review. (1) Upon receipt of a proposed management agreement, the department may require:

(a) The adult family home to provide additional information or clarification;

(b) Changes necessary to:

(i) Bring the management agreement into compliance with this chapter; and

(ii) Ensure that the adult family home has continued to have ultimate responsibility for the daily operations of the home.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11065, filed 1/15/10, effective 2/15/10.]

WAC 388-76-11070 Management agreements—Resident funds. (1) If the management agreement delegates day-to-day management of resident personal funds to the manager, the adult family home must:

(a) Retain all fiduciary and custodial responsibility for funds that have been deposited with the adult family home by the resident;

(b) Remain directly accountable to the residents and resident representatives for such funds; and

(c) Ensure any party responsible for holding or managing resident's personal funds:

(i) Is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds;

(ii) Provides proof of bond or insurance; and

(iii) Provides proof of payment of the bond or insurance premium.

(2) If responsibilities for the day-to-day management of the resident funds are delegated to the manager, the manager must:

(a) Give the adult family home a monthly accounting of the residents' funds;

(b) Meet all legal requirements related to holding, and accounting for, resident funds; and

(c) Comply with all requirements under this chapter relating to residents rights and financial affairs.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11070, filed 1/15/10, effective 2/15/10.]

WAC 388-76-11080 Notice—Service complete. Service of the department notices is complete when:

(1) Personal service is made;

(2) The notice is addressed to the home or the individual at his or her last known address, and deposited in the United States mail;

(3) The notice is faxed and the department receives evidence of transmission;

(4) Notice is delivered to a commercial delivery service with charges prepaid; or

(5) Notice is delivered to a legal messenger service with charges prepaid.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11080, filed 1/15/10, effective 2/15/10.]

WAC 388-76-11085 Notice—Proof of service. The department may establish proof of service by any of the following:

(1) A declaration of personal service;

(2) An affidavit or certificate of mailing to the adult family home or to the individual to whom the notice is directed;

(3) A signed receipt from the person who accepted the certified mail, the commercial delivery service, or the legal messenger service package; or

(4) Proof of fax transmission.

[Statutory Authority: RCW 70.128.040. 10-03-064, § 388-76-11085, filed 1/15/10, effective 2/15/10.]

Chapter 388-78A WAC
BOARDING HOME LICENSING RULES

(Formerly chapter 246-316 WAC)

WAC

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WAC 388-78A-2060 Preadmission assessment. The boarding home must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the boarding home:

(1) Medical history;

(2) Necessary and contraindicated medications;

(3) A licensed medical or health professional's diagnosis, unless the prospective resident objects for religious reasons;

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(5) Mental illness diagnosis, except where protected by confidentiality laws;

(6) Level of personal care needs;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2060, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2060, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2300 Food and nutrition services. (1) The boarding home must:

(a) Provide a minimum of three meals a day:

(i) At regular intervals;

(ii) With no more than fourteen hours between the evening meal and breakfast, unless the boarding home provides a nutritious snack after the evening meal and before breakfast.

(b) Provide sufficient time and staff support for residents to consume meals;

(c) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;

(ii) Indicate the date, day of week, month and year;

(iii) Include all food and snacks served that contribute to nutritional requirements;

(iv) Are kept at least six months;

(v) Provide a variety of foods; and

(vi) Are not repeated for at least three weeks, except that breakfast menus in boarding homes that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(d) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC Food service;

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(i) Age, gender and activities, unless medically contraindicated; and

(ii) Individual preferences to the extent reasonably possible.

(f) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The boarding home is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

(h) Develop, make known to residents, and implement a process for residents to express their views and comment on the food services; and

(i) Maintain a dining area or areas approved by the department with a seating capacity for fifty percent or more of the residents per meal setting, or ten square feet times the licensed resident bed capacity, whichever is greater.

(2) The boarding home must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The boarding home must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

(b) Prescribed nutrient concentrates and supplements when prescribed in writing by a health care practitioner.

(3) The boarding home may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

(a) Modified or therapeutic diets;

(b) Nutritional concentrates or supplements.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2300, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2300, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2300, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2440 Resident register. (1) The boarding home must maintain in the boarding home a single current register of all boarding home residents, their roommates and identification of the rooms in which such persons reside or sleep.

(2) The boarding home must maintain a readily available permanent, current book, computer file, or register with entries in ink or typewritten, of all individuals who resided in the boarding home within the past five years, including:

(a) Move-in date;

(b) Full name;

(c) Date of birth;

(d) Date of moving out;

(e) Reason for moving out; and

(f) Location and address to which the resident was discharged.

(3) The boarding home must make this register immediately available to:

(a) Authorized department staff;

(b) Representatives of the long-term care ombudsman's office; and

(c) Representatives of the Washington state fire marshal when conducting fire safety inspections.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2440, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2440, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2450 Staff. (1) Each boarding home must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the boarding home free of safety hazards; and

(c) Implement fire and disaster plans.

(2) The boarding home must:

(a) Develop and maintain written job descriptions for the administrator and each staff position and provide each staff person with a copy of his or her job description before or upon the start of employment;

(b) Verify staff persons' work references prior to hiring;

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the boarding home premises; and

(ii) During boarding home activities off of the boarding home premises.

(g) Ensure caregiver provides on-site supervision of any resident voluntarily providing services for the boarding home;

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of boarding home;

(ii) Physical boarding home layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and boarding home policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

(i) Develop and implement a process to ensure caregivers:

(i) Acquire the necessary information from the preadmission assessment, on-going assessment and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;

(ii) Are informed of changes in the negotiated service agreement of each resident with whom the caregiver works; and

(iii) Are given an opportunity to provide information to responsible staff regarding the resident when assessments and negotiated service agreements are updated for each resident with whom the caregiver works.

(j) Ensure all caregivers have access to resident records relevant to effectively providing care and services to the resident.

(3) The boarding home must:

(a) Protect all residents by ensuring any staff person suspected or accused of abuse, neglect, financial exploitation, or abandonment does not have access to any resident until the boarding home investigates and takes action to ensure resident safety;

(b) Not interfere with the investigation of a complaint, coerce a resident or staff person regarding cooperating with a complaint investigation, or conceal or destroy evidence of alleged improprieties occurring within the boarding home;

(c) Prohibit staff persons from being directly employed by a resident or a resident's family during the hours the staff person is working for the boarding home;

(d) Maintain the following documentation on the boarding home premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112 WAC;

(B) Home care aide certification as required by this chapter and chapter 246-980 WAC;

(C) Cardiopulmonary resuscitation;

(D) First aid; and

(E) HIV/AIDS training.

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471; and

(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

(4) The boarding home is not required to keep on the boarding home premises, staff records that are unrelated to staff performance of duties. Such records include, but are not limited to, pay records, and health and insurance benefits for staff.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2450, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2450, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2461 Background check—General. Background checks conducted by the department and required in this chapter include but are not limited to:

(1) Washington state background checks including:

(a) Department and department of health findings;

(b) Criminal background check information from the Washington state patrol and the Washington state courts;

(2) After January 1, 2012, a national fingerprint-based check in accordance with RCW 74.39A.055.

(3) Nothing in this chapter should be interpreted as requiring the employment of a person against the better judgment of the boarding home.

(4) In addition to chapter 18.20 RCW, these rules are authorized by RCW 43.20A.710, RCW 43.43.830 through 43.43.842 and RCW 74.39A.050(8).

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2461, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2462 Background check—Washington state—Who is required to have. (1) Applicants, as defined in WAC 388-78A-2740, are required to have a Washington state background check before licensure.

(2) The boarding home must ensure the following have Washington state background checks:

(a) Caregivers, including volunteers who are not residents, and students who may have unsupervised access to residents;

(b) Administrators;

(c) Licensee;

(d) Staff persons;

(e) Managers; and

(f) Contractors who may have unsupervised access to residents.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2462, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2463 Background check—National fingerprint checks—Who is required to have. (1) After January 1, 2012, applicants for a boarding home license must have a background check that includes a national fingerprint-based background check.

(2) The boarding home must ensure that all caregivers hired after January 1, 2012 have a background check that includes a national fingerprint-based background check.

(3) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2463, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2464 Background check—Process. (1) Before the boarding home employs, directly or by contract, an administrator, staff person or caregiver, or accepts as a caregiver, any volunteer who is not a resident, or student, the home must:

(a) Require the person to complete a DSHS background authorization form; and

(b) Send the completed form to the department's background check central unit (BCCU), including any additional documentation and information requested by the department.

(2) For purposes of this section, the administrator is presumed to provide direct care.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2464, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2465 Background check—Results. (1) The boarding home must not allow the persons listed in WAC 388-78A-2462(2) to have unsupervised access to residents until the boarding home receives background check results from the department verifying that the person does not have any convictions, or findings described in WAC 388-78A-2470.

(2) If the background check results show that the person has a conviction or finding that is not disqualifying under WAC 388-78A-2470, then the boarding home must determine whether the person has the character, suitability and competence to work with vulnerable adults in long-term care.

(3) The boarding home must:

(a) Inform the person of the results of the background check;

(b) Inform the person that they may request a copy of the results of the background check. If requested, a copy of the background check results must be provided within ten days of the request; and

(c) Notify the department and other appropriate licensing or certification agency of any person resigning or terminated as a result of having a conviction record.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2465, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2466 Background check—Valid for two years. A Washington state background check is valid for two years from the initial date it is conducted. The boarding home must ensure:

(1) A new DSHS background authorization form is submitted to BCCU every two years for individuals listed in WAC 388-78A-2462; and

(2) There is a valid Washington state background check for all individuals listed in WAC 388-78A-2462.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2466, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2467 Background check—Sharing by health care facilities. In accordance with RCW 43.43.832 a health care facility may share Washington state background check results with other health care facilities under certain circumstances. Results of the national fingerprint checks may not be shared. For the purposes of this section health care facility means a nursing home licensed under chapter 18.51 RCW, a boarding home license under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

(1) The health care facility may, upon request from another health care facility, share completed Washington state background check results only if:

(a) The health care facility sharing the background check information is reasonably known to be the person's most recent employer;

(b) No more than twelve months has elapsed between the date the individual was last employed at a licensed health care facility and the date of the individual's current employment application;

(c) The background check is no more than two years old; and

(d) The boarding home has no reason to believe the individual has or may have a disqualifying conviction or finding as described in WAC 388-78A-2470.

(2) The boarding home may also establish, maintain and follow a written agreement with home health, hospice, or home care agencies licensed under chapter 70.127 RCW or nursing pools registered under chapter 18.52C RCW in order to ensure that the agency or pool staff meet the requirements of WAC 388-78A-2470.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2467, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2468 Background check—Conditional hire—Pending results. The boarding home may conditionally hire an individual described in WAC 388-78A-2462, directly or by contract, pending the result of a background check, provided that the boarding home:

(1) Submits the background authorization form for the individual to the department no later than one business day after the individual starts working;

(2) Requires the individual to sign a disclosure statement, and the individual denies having been convicted of a disqualifying crime or have a disqualifying finding under WAC 388-78A-2470;

(3) Has received three positive references for the individual;

(4) Does not allow the individual to have unsupervised access to any resident;

(5) Ensures direct supervision, of the individual, as defined in RCW 18.20.270; and

(6) Ensures that the person is competent, and receives the necessary training to perform assigned tasks.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2468, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2469 Background check—Disclosure statement. (1) Prior to first starting his or her duties, the boarding home must require each individual described in WAC 388-78A-2462 to make disclosures, consistent with RCW 43.43.834(2). The disclosures must be in writing and signed by the individual under penalty of perjury.

(2) The department may require the boarding home or any individual described in WAC 388-78A-2462 to complete additional disclosure statements or background authorization forms if the department has reason to believe that offenses specified in WAC 388-78A-2470 have occurred since completion of the previous disclosure statement or background check.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2469, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2470 Background check—Employment-disqualifying information. The boarding home must not allow an individual described in WAC 388-78A-2462 to have unsupervised access to residents, as defined in RCW 43.43.830, if the individual has been:

(1) Convicted of a "crime against children or other persons" as defined in RCW 43.43.830, unless the crime is simple assault, assault in the fourth degree, or prostitution and more than three years has passed since the last conviction;

(2) Convicted of "crimes relating to financial exploitation" as defined in RCW 43.43.830, unless the crime is theft in the third degree, and more than three years have passed since conviction, or unless the crime is forgery or theft in the second degree and more than five years has passed since conviction;

(3) Convicted of:

(a) Violation of the Imitation Controlled Substances Act (VICSA);

(b) Violation of the Uniform Controlled Substances Act (VUCSA);

(c) Violation of the Uniform Legend Drug Act (VULDA); or

(d) Violation of the Uniform Precursor Drug Act (VUPDA);

(4) Convicted of sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;

(5) Convicted of criminal mistreatment;

(6) Convicted of a crime in federal court or in any other state, and the department determines that the crime is equivalent to a crime described in this subsection;

(7) Found to have abused, neglected, financially exploited or abandoned a minor or vulnerable adult by a court of law or a disciplining authority, including the department of health;

(8) Found to have abused or neglected a child and that finding is:

(a) Listed on the department's background check central unit (BCCU) report; or

(b) Disclosed by the individual, except for finding made before December, 1998.

(9) Found to have abused, neglected, financially exploited or abandoned a vulnerable adult and that finding is:

(a) Listed on any registry, including the department's registry;

(b) Listed on the department's background check central unit (BCCU) report; or

(c) Disclosed by the individual, except for adult protective services findings made before October, 2003.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2470, filed 7/30/10, effective 1/1/11. Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2470, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapters 18.20 and 74.34 RCW. 09-01-052, § 388-78A-2470, filed 12/10/08, effective 1/10/09. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-2470, filed 2/15/08, effective 3/17/08. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2470, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2470, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2471 Background check—Confidentiality—Use restricted—Retention. The boarding home must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

(2) Used for employment purposes only;

(3) Not disclosed to anyone except to the individual, authorized state and federal employees, the Washington state patrol auditor, persons or health care facilities authorized by chapter 43.43 RCW; and

(4) Retained and available for department review during the individual's employment or association with a facility and for at least two years after termination of the employment or association.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2471, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2474 Training and home care aide certification. (1) The boarding home must ensure staff persons hired before January 1, 2011 meet training requirements in effect on the date hired, including requirements in chapter 388-112 WAC.

(2) The boarding home must ensure all boarding home administrators, or their designees, and caregivers hired on or after January 1, 2011 meet the long-term care worker training requirements of chapter 388-112 WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic;

(c) Specialty for dementia, mental illness and /or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) The boarding home must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification required by chapter 246-980 WAC.

(4) Under RCW 18.88B.040 and chapter 246-980 WAC, certain persons including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant program are exempt from long-term care worker training requirements.

(5) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2474, filed 7/30/10, effective 1/1/11.]

WAC 388-78A-2480 Tuberculosis—Testing—Required. (1) The boarding home must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-78A-2481 through 388-78A-2489, "staff person" means any boarding home employee or temporary employee of the boarding home, excluding volunteers and contractors.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2480, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090. 06-24-073, § 388-78A-2480, filed 12/4/06, effective 1/4/07; 06-01-047, § 388-78A-2480, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2480, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2481 Tuberculosis—Testing method—Required. The boarding home must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

(b) By a trained professional; or

(2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2481, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2482 Tuberculosis—No testing. The boarding home is not required to have a staff person tested for tuberculosis if the staff person has:

(1) A documented history of a previous positive skin test, with ten or more millimeters induration;

(2) A documented history of a previous positive blood test; or

(3) Documented evidence of:

(a) Adequate therapy for active disease; or

(b) Completion of treatment for latent tuberculosis infection preventive therapy.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2482, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2483 Tuberculosis—One test. The boarding home is only required to have a staff person take one test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two step skin test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2483, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2484 Tuberculosis—Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the boarding home choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2484, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2485 Tuberculosis—Positive test result. When there is a positive result to tuberculosis skin or blood testing the boarding home must:

(1) Ensure that the staff person has a chest X-ray within seven days;

(2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the resident or staff person's health care provider.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2485, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2486 Tuberculosis—Negative test result. The boarding home may be required by the public health provider or licensing authority to ensure that staff persons with negative test results have follow-up testing in certain circumstances, such as:

(1) After exposure to active tuberculosis;

(2) When tuberculosis symptoms are present; or

(3) For periodic testing as determined by the public health provider.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2486, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2487 Tuberculosis—Declining a skin test. The boarding home must ensure that a staff person take the blood test for tuberculosis if they decline the skin test.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2487, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2488 Tuberculosis—Reporting—Required. The boarding home must:

(1) Report any staff person or resident with tuberculosis symptoms or a positive chest X ray to the appropriate health care provider, or public health provider;

(2) Follow the infection control and safety measures ordered by the staff person's health care provider including a public health provider;

(3) Institute appropriate infection control measures;

(4) Apply living or work restrictions where residents or staff persons are, or may be, infectious and pose a risk to other residents and staff persons; and

(5) Ensure that staff person's caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection found in chapter 296-842 WAC.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2488, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2489 Tuberculosis—Test records. The boarding home must:

(1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the boarding home;

(2) Make the records readily available to the appropriate health provider and licensing agency,

(3) Retain the records for at least two years after the date the staff person either quits or is terminated; and

(4) Provide the staff person a copy of his/her test results.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2489, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2490 Specialized training for developmental disabilities. The boarding home must ensure completion of specialized training, consistent with chapter 388-112 WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the boarding home has a developmental disability as defined in WAC 388-823-0040, that is the resident's primary special need.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2490, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2490, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2490, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2500 Specialized training for mental illness. The boarding home must ensure completion of specialized training, consistent with chapter 388-112 WAC, to serve residents with mental illness, whenever at least one of the residents in the boarding home has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, and:

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2500, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2500, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2500, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2510 Specialized training for dementia. The boarding home must ensure completion of specialized training, consistent with chapter 388-112 WAC, to serve residents with dementia, whenever at least one of the residents in the boarding home has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2510, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2510, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2510, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2520 Administrator qualifications—General. (1) The licensee must appoint an administrator who is:

(a) At least twenty-one years old;

(b) Not a resident of the boarding home; and

(c) Qualified to perform the administrator's duties specified in WAC 388-78A-2560.

(2) The licensee must only appoint as a boarding home administrator an individual who meets the requirements of at least one of the following sections in WAC 388-78A-2522 through 388-78A-2527.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2520, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2520, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2520, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2521 Certification of training. As used in WAC 388-78A-2522 through 388-78A-2527, an individual obtains certification of training as follows. The individual has certification of completing a recognized administrator training course that consists of a minimum of twenty-four hours of instruction or equivalent online training, or certification of passing an administrator examination from or endorsed by a department-recognized national accreditation health or personal care organization such as:

(1) The American association of homes and services for the aging;

(2) The American college of health care administrators;

(3) The American health care association;

(4) The assisted living federation of America; or

(5) The national association of board of examiners of long term care administrators.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2521, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2522 Administrator qualifications—Prior to 2004. The individual was actively employed as a boarding home administrator and met existing qualifications on September 1, 2004.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2522, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2523 Administrator qualifications—NH administrator license. The individual holds a current Washington state nursing home administrator license in good standing.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2523, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2524 Administrator qualifications—Certification of training, and three years experience. Prior to assuming duties as a boarding home administrator, the individual has met the following qualifications:

(1) Obtained certification of completing a recognized administrator training as referenced in WAC 388-78A-2521; and

(2) Has three years paid experience:

(a) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family

home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; and/or

(b) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2524, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2525 Administrator qualifications—Associate degree, certification of training, and two years experience. The individual holds an associate degree in a related field of study such as health, social work, or business administration and meets the qualifications listed in either subsection (1), (2) or (3) of this section:

(1) Obtains certification of completing a recognized administrator training course as referenced in WAC 388-78A-2521 within six months of beginning duties as the administrator; or

(2) Has two years paid experience:

(a) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; and/or

(b) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; or

(3) Has completed a qualifying administrator training program supervised by a qualified administrator according to WAC 388-78A-2530.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2525, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2526 Administrator qualifications—Bachelor's degree, certification of training, and one year experience. The individual holds a bachelor's degree in a related field of study such as health, social work, or business administration and meets the qualifications listed in either subsection (1), (2) or (3) of this section.

(1) Obtains certification of completing a recognized administrator training course and referenced in WAC 388-78A-2521 within six months of beginning duties as the administrator; or

(2) Has one year paid experience:

(a) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; and/or

(b) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; or

(3) Has completed a qualifying administrator training program supervised by a qualified administrator according to WAC 388-78A-2530.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2526, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2527 Administrator qualifications—Five years experience. Before assuming duties as an administrator, the individual has five years of paid experience:

(1) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; and/or

(2) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2527, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2540 Administrator requirements. The licensee must ensure the boarding home administrator:

(1) Meets the training requirements under chapter 388-112 WAC; and

(2) Knows and understands how to apply Washington state statutes and administrative rules related to the operation of a boarding home; and

(3) Meets the administrator qualification requirements referenced in WAC 388-78A-2520 through 388-78A-2527.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2540, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2540, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2550 Administrator training documentation. The boarding home must maintain for department review, documentation of the administrator completing:

(1) Training required by chapter 388-112 WAC;

(2) Department training in an overview of Washington state statutes and administrative rules related to the operation of a boarding home;

(3) As applicable, certification from a department-recognized national accreditation health or personal care organization; and

(4) As applicable, the qualifying administrator-training program.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2550, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2550, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2590 Management agreements—General. (1) If the proposed or current licensee uses a manager, the licensee must have a written management agree-

ment approved by the department that is consistent with this chapter.

(2) The proposed or current licensee must notify the department of its use of a manager upon:

(a) Initial application for a license;

(b) Retention of a manager following initial application;

(c) Change of managers; and

(d) Modification of existing management agreement.

(3) The proposed or current licensee must provide a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations.

(4) The written management agreement must be submitted:

(a) Sixty days before:

(i) The initial licensure date;

(ii) The proposed change of ownership date; or

(iii) The effective date of the management agreement; or

(b) Thirty days before the effective date of any amendment to an existing management agreement.

(5) The proposed licensee or the current licensee must notify the resident and their representatives sixty days before entering into a management agreement.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2590, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2590, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2592 Management agreements—Licensee. (1) The licensee is responsible for:

(a) The daily operations and provisions of services in the boarding home (see 388-78A-2730 (1)(a));

(b) Ensuring the boarding home is operated in a manner consistent with all laws and rules applicable to boarding homes (see 388-78A-2730 (1)(b));

(c) Ensuring the manager acts in conformance with a department approved management agreement; and

(d) Ensuring the manager does not represent itself as, or give the appearance that it is the licensee.

(2) The licensee must not give the manager responsibilities that are so extensive that the licensee is relieved of daily responsibility for the daily operations and provision of services in the boarding home. If the licensee does so, then the department must determine that a change of ownership has occurred.

(3) The licensee and manager must act in accordance with the terms of the department-approved management agreements. If the department determines they are not, then the department may take licensing action.

(4) The licensee may enter into a management agreement only if the management agreement creates a principal/agent relationship between the licensee and manager.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2592, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2593 Management agreements—Terms of agreement. Management agreements, at a minimum must:

(1) Describe the responsibilities of the licensee and manager, including items, services, and activities to be provided;

(2) Require the licensee's governing body, board of directors, or similar authority to appoint the facility administrator;

(3) Provide for the maintenance and retention of all records in accordance with this chapter and other applicable laws;

(4) Allow unlimited access by the department to documentation and records according to applicable laws or regulations;

(5) Require the manager to immediately send copies of inspections and notices of noncompliance to the licensee;

(6) State that the licensee is responsible for reviewing, acknowledging and signing all boarding home initial and renewal license applications;

(7) State that the manager and licensee will review the management agreement annually and notify the department of any change according to applicable regulations;

(8) Acknowledge that the licensee is the party responsible for complying with all laws and rules applicable to boarding homes;

(9) Require the licensee to maintain ultimate responsibility over personnel issues relating to the operation of the boarding home and care of the residents, including but not limited to, staffing plans, orientation and training;

(10) State the manager will not represent itself, or give the appearance it is the licensee; and

(11) State that a duly authorized manager may execute resident leases or agreements on behalf of the licensee, but all such resident leases or agreements must be between the licensee and the resident.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2593, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2594 Management agreements—Department review. Upon receipt of a proposed management agreement, the department may require:

(1) The proposed or current licensee or manager to provide additional information or clarification;

(2) Any changes necessary to:

(a) Bring the management agreement into compliance with this chapter; and

(b) Ensure that the licensee has not been relieved of the responsibility for the daily operations of the facility.

(3) The licensee to participate in monthly meetings and quarterly on-site visits to the boarding home.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2594, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2595 Management agreements—Resident funds. (1) If the management agreement delegates day-to-day management of resident funds to the manager, the licensee:

(a) Retains all fiduciary and custodial responsibility for funds that have been deposited with the boarding home by the resident;

(b) Is directly accountable to the residents for such funds; and

(c) Must ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds; and provides proof of bond or insurance.

(2) If responsibilities for the day-to-day management of the resident funds are delegated to the manager, the manager must:

(a) Provide the licensee with a monthly accounting of the resident funds; and

(b) Meet all legal requirements related to holding, and accounting for, resident funds.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2595, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2665 Resident rights—Notice—Policy on accepting medicaid as a payment source. The boarding home must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the boarding home provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2665, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2732 Liability insurance required—Ongoing. The boarding home must:

(1) Obtain liability insurance upon licensure and maintain the insurance as required in WAC 388-78A-2733 and 388-78A-2734; and

(2) Have evidence of liability insurance coverage available if requested by the department.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2732, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2733 Liability insurance required—Commercial general liability insurance or business liability insurance coverage. The boarding home must have commercial general liability insurance or business liability insurance that includes:

(1) Coverage for the acts and omissions of any employee and volunteer;

(2) Coverage for bodily injury, property damage, and contractual liability;

(3) Coverage for premises, operations, independent contractor, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract; and

(4) Minimum limits of:

(a) Each occurrence at one million dollars; and

(b) General aggregate at two million dollars.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2733, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2734 Liability insurance required—Professional liability insurance coverage. The boarding home must have professional liability insurance or error and omissions insurance if the boarding home licensee has a professional license, or employs professionally licensed staff. The insurance must include:

(1) Coverage for losses caused by errors and omissions of the boarding home, its employees, and volunteers; and

(2) Minimum limits of:

(a) Each occurrence at one million dollars; and

(b) Aggregate at two million dollars.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2734, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-2750 Application process. To apply for a boarding home license, a person must:

(1) Submit to the department a complete license application on forms designated by the department at least ninety days prior to the proposed effective date of the license;

(2) Submit all relevant attachments specified in the application;

(3) Submit department background authorization forms as required in WAC 388-78A-2462 and 388-78A-2463;

(4) Sign the application;

(5) Submit the license fee as specified in WAC 388-78A-3230;

(6) Submit verification that construction plans have been approved by construction review services;

(7) Submit a revised application before the license is issued if any information has changed since the initial license application was submitted;

(8) Submit a revised application containing current information about the proposed licensee or any other persons named in the application, if a license application is pending for more than one year; and

(9) If the licensee's agent prepares an application on the licensee's behalf, the licensee must review, sign and attest to the accuracy of the information contained in the application.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-2750, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2750, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2910 Applicable building codes. (1) Newly licensed boarding homes and new construction in existing boarding homes must meet the requirements of all the current state and local building and zoning codes and applicable sections of this chapter.

(2) Existing licensed boarding homes must continue to meet the building codes in force at the time of their plan approval by construction review services, except that the boarding home may be required to meet current building code requirements if the construction poses a risk to the health and safety of residents.

(3) The boarding home must ensure that construction is completed in compliance with the final construction review services approved documents. Compliance with these standards and regulations does not relieve the boarding home of the need to comply with applicable state and local building and zoning codes.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-2910, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2910, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2910, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3030 Toilet rooms and bathrooms. (1) The boarding home must provide private or common-use toilet rooms and bathrooms to meet the needs of each resident.

(2) The boarding home must provide each toilet room and bathroom with:

(a) Water resistant, smooth, low gloss, nonslip and easily cleanable materials;

(b) Washable walls to the height of splash or spray;

(c) Grab bars installed and located to minimize accidental falls including one or more grab bars at each:

(i) Bathing fixture; and

(ii) Toilet.

(d) Plumbing fixtures designed for easy use and cleaning and kept in good repair; and

(e) Adequate ventilation to the outside of the boarding home. For boarding homes issued a project number by construction review services on or after September 1, 2004, for construction related to this section, must provide mechanical ventilation to the outside.

(3) The boarding home must provide each toilet room with a:

(a) Toilet with a clean, nonabsorbent seat free of cracks;

(b) Handwashing sink in or adjacent to the toilet room. For boarding homes issued a project number by construction review services on or after September 1, 2004, for construction related to this section, the handwashing sink must be in the toilet room or in an adjacent private area that is not part of a common use area of the boarding home; and

(c) Suitable mirror with adequate lighting for general illumination.

(4) For boarding homes approved for construction or initially licensed after August 1, 1994, the boarding home must provide a toilet and handwashing sink in, or adjoining, each bathroom.

(5) When providing common-use toilet rooms and bathrooms, the boarding home must provide toilets and handwashing sinks for residents in the ratios of one toilet and one handwashing sink for every eight residents. For example: One toilet and one handwashing sink for one to eight residents, two for nine to sixteen residents, three for seventeen to twenty-four residents, and so on, who do not have access to a private toilet room. When two or more toilets are contained in a single bathroom, they are counted as one toilet.

(6) When providing common-use toilet rooms and bathrooms, the boarding home must provide bathing fixtures for residents in the ratio of one bathing fixture for every twelve residents. For example: One bathing fixture for one to twelve residents, two for twelve to twenty-four residents, three for twenty-five to thirty-six residents, and so on, who do not have access to a private toilet room.

(7) When providing common-use toilet rooms and bathrooms, the boarding home must:

(a) Designate toilet rooms containing more than one toilet for use by men or women;

(b) Designate bathrooms containing more than one bathing fixture for use by men or women;

(c) Equip each toilet room and bathroom designed for use by, or used by, more than one person at a time, in a manner to ensure visual privacy for each person using the room. The boarding home is not required to provide additional privacy features in private bathrooms with a single toilet and a single bathing fixture located within a private apartment;

(d) Provide a handwashing sink with soap and single use or disposable towels, blower or equivalent hand-drying device in each toilet room, except that single-use or disposable towels or blowers are not required in toilet rooms or bathrooms that are located within a private apartment;

(e) Provide reasonable access to bathrooms and toilet rooms for each resident by:

(i) Locating a toilet room on the same floor or level as the sleeping room of the resident served;

(ii) Locating a bathroom on the same floor or level, or adjacent floor or level, as the sleeping room of the resident served;

(iii) Providing access without passage through any kitchen, pantry, food preparation, food storage, or dishwashing area, or from one bedroom through another bedroom; and

(f) Provide and ensure toilet paper is available at each common-use toilet.

(8) In boarding homes issued a project number by construction review services on or after September 1, 2004, for construction related to this section, the boarding home must ensure twenty-five percent of all the bathing fixtures in the boarding home are roll-in type showers that have:

(a) One-half inch or less threshold that may be a collapsible rubber water barrier;

(b) A minimum size of thirty-six inches by forty-eight inches; and

(c) Single lever faucets located within thirty-six inches of the seat so the faucets are within reach of persons seated in the shower.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3030, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapters 18.20 and 74.34 RCW. 09-01-052, § 388-78A-3030, filed 12/10/08, effective 1/10/09. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-3030, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3030, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3190 Denial, suspension, revocation, or nonrenewal of license statutorily required. (1) The department must deny, suspend, revoke, or refuse to renew a boarding home license if any person described in subsection (2) of this section who may have unsupervised access to residents has a conviction or finding described in WAC 388-78A-2470.

(2) This section applies to any boarding home:

(a) Applicant;

(b) Partner, officer or director;

(c) Manager or managerial employee; or

(d) Owner of five percent or more of the applicant:

(i) Who is involved in the operation of the boarding home; or

(ii) Who controls or supervises the provision of care or services to the boarding home residents; or

(iii) Who exercises control over daily operations.

[Statutory Authority: Chapters 18.20 and 74.39A RCW. 10-16-085, § 388-78A-3190, filed 7/30/10, effective 1/1/11. Statutory Authority: Chapter

18.20 RCW. 10-03-066, § 388-78A-3190, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-3190, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3190, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3230 Fees. The boarding home must:

(1) Submit an annual license fee of one hundred six dollars per bed of the licensed resident bed capacity as determined by and in accordance with RCW 18.20.050;

(2) Submit an additional one hundred fifty dollars when billed by the department for:

(a) A third on-site visit required by the boarding home's failure to adequately correct problems identified in a statement of deficiencies; and

(b) A full out-of-sequence inspection resulting from information gathered during a complaint investigation.

(3) Submit an additional late fee in the amount of ten dollars per day from the license renewal date until the date of mailing the fee, as evidenced by the postmark; and

(4) Submit to construction review services a fee for the review of the construction documents per the review fee schedule that is based on the project cost.

[Statutory Authority: RCW 18.20.050 and 2010 c 37 § 206 (19)(a). 10-21-036, § 388-78A-3230, filed 10/12/10, effective 10/29/10. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3230, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3390 Resident protection program—Individual defined. As used in WAC 388-78A-3400 through 388-78A-3480, the term "individual" means anyone used by the boarding home to provide services to residents who is alleged to have abandoned, abused, neglected, or financially exploited a resident. "Individual" includes, but is not limited to employees, contractors, and volunteers.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3390, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-3410 Resident protection program—Notice to the individual of preliminary finding. (1) The department will serve notice of the preliminary finding as provided in WAC 388-78A-4000.

(2) The department may establish proof of service as provided in WAC 388-78A-4010.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3410, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-3410, filed 2/15/08, effective 3/17/08.]

WAC 388-78A-3420 Resident protection program—Notice to others of preliminary findings. Consistent with confidentiality requirements concerning the resident, witnesses, and reporter, the department may provide notification of a preliminary finding to:

(1) Other divisions within the department;

(2) The agency, program, or employer where the incident occurred;

(3) The employer or program that is currently associated with the individual;

(4) Law enforcement;

(5) Other entities as authorized by law including chapter 74.34 RCW and this chapter; and

(6) The appropriate licensing agency.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3420, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-3420, filed 2/15/08, effective 3/17/08.]

WAC 388-78A-3430 Resident protection program—Disputing a preliminary finding. (1) The individual may request an administrative hearing to challenge a preliminary finding made by the department.

(2) The request must be made in writing to the office of administrative hearings.

(3) The office of administrative hearings must receive the individual's written request for an administrative hearing within thirty calendar days of the date written on the notice of the preliminary finding.

(4) The written request for a hearing must include:

(a) The individual's full legal name, current mailing address and the telephone number;

(b) A brief explanation of why the individual disagrees with the preliminary finding;

(c) A description of any assistance needed in the administrative appeal process by the individual, including a foreign or sign language interpreter or any reasonable accommodation for a disability; and

(d) The individual's signature.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3430, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-3430, filed 2/15/08, effective 3/17/08.]

WAC 388-78A-3450 Resident protection program—Finalizing a preliminary finding. (1) A preliminary finding becomes a final finding when:

(a) The department notifies the individual there is a preliminary finding under WAC 388-78A-3410; and

(b) The individual does not ask for an administrative hearing; or

(c) The administrative law judge:

(i) Dismisses the appeal following withdrawal of the appeal or default;

(ii) Dismisses the appeal for failure to comply with time limits under WAC 388-78A-3430; or

(iii) Issues an initial order upholding the finding and the individual fails to appeal the initial order to the department's board of appeals.

(d) The board of appeals issues a final order upholding the finding.

(2) A final finding is permanent.

(3) A final finding will only be removed from the department or agency list of individuals found to have abandoned, abused, neglected, exploited, or financially exploited a vulnerable adult if it is rescinded following judicial review.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3450, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapters 18.20 and 74.34 RCW. 09-01-052, § 388-78A-3450, filed 12/10/08, effective 1/10/09. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-3450, filed 2/15/08, effective 3/17/08.]

WAC 388-78A-3460 Resident protection program—Appeal of initial order. (1) If the individual or the department disagrees with the administrative law judge's decision,

either party may challenge this decision by filing a petition for review with the department's board of appeals under chapter 34.05 RCW, Administrative Procedure Act, and chapter 388-02 WAC.

(2) If the department appeals the administrative law judge's decision, the department will not change the finding in the department's records until a final hearing decision is issued.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3460, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapters 18.20 and 74.34 RCW. 09-01-052, § 388-78A-3460, filed 12/10/08, effective 1/10/09. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-3460, filed 2/15/08, effective 3/17/08.]

WAC 388-78A-3470 Resident protection program—Reporting final findings. The department will report a final finding of abandonment, abuse, neglect, exploitation and financial exploitation within ten workings days to the following:

(1) The individual against whom the final finding was made;

(2) The boarding home licensee or entity representative that was associated with the individual during the time of the incident;

(3) The employer or program that is currently associated with the individual against whom the final finding was made, if known;

(4) The appropriate licensing, certification or registration authority;

(5) Any federal or state registry or list of individuals found to have abandoned, abused, neglected, exploited, or financially exploited a vulnerable adult; and

(6) The findings may be disclosed to the public upon request subject to applicable public disclosure laws.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3470, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-3470, filed 2/15/08, effective 3/17/08.]

WAC 388-78A-3480 Resident protection program—Disclosure of investigative and finding information. (1) Confidential information about residents and mandated reporters received from the department may only be used by the individual to challenge findings through the appeal process. It may only be shared with persons who are involved in the appeal.

(2) Confidential information such as the name and other personal identifying information of the reporter, witnesses, or the resident will be redacted from documents unless release of that information is consistent with chapter 74.34 RCW and other applicable state and federal laws.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-3480, filed 1/15/10, effective 2/15/10. Statutory Authority: RCW 18.20.090 and chapters 18.20 and 74.34 RCW. 08-05-099, § 388-78A-3480, filed 2/15/08, effective 3/17/08.]

WAC 388-78A-4000 Notice—Service complete. Service of the department notices is complete when:

(1) Personal service is made;

(2) The notice is addressed to the individual or facility at his or her last known address, and deposited in the United States mail;

(3) The notice is faxed and the department receives evidence of transmission;

(4) Notice is delivered to a commercial delivery service with charges prepaid; or

(5) Notice is delivered to a legal messenger service with charges prepaid.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-4000, filed 1/15/10, effective 2/15/10.]

WAC 388-78A-4010 Notice—Proof of service. The department may establish proof of service by any of the following:

(1) A declaration of personal service;

(2) An affidavit or certificate of mailing to the boarding home or to the individual to whom notice is directed;

(3) A signed receipt from the person who accepted the certified mail, the commercial delivery service, or the legal messenger service package; or

(4) Proof of fax transmission.

[Statutory Authority: Chapter 18.20 RCW. 10-03-066, § 388-78A-4010, filed 1/15/10, effective 2/15/10.]

Chapter 388-97 WAC
NURSING HOMES

WAC

388-97-4160 Initial nursing home license.
388-97-4180 Nursing home license renewal.

WAC 388-97-4160 Initial nursing home license. (1) A complete nursing home license application must be:

(a) Submitted at least sixty days prior to the proposed effective date of the license on forms designated by the department;

(b) Signed by the proposed licensee or the proposed licensee's authorized representative;

(c) Notarized; and

(d) Reviewed by the department in accordance with this chapter.

(2) All information requested on the license application must be provided. At minimum, the nursing home license application will require the following information:

(a) The name and address of the proposed licensee, and any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee;

(b) The names of the administrator, director of nursing services, and, if applicable, the management company;

(c) The specific location and the mailing address of the facility for which a license is sought;

(d) The number of beds to be licensed; and

(e) The name and address of all nursing homes that the proposed licensee or any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee has been affiliated with in the past ten years.

(3) The proposed licensee must be:

(a) The individual or entity responsible for the daily operation of the nursing home;

(b) Denied the license if any individual or entity named in the application is found by the department to be unqualified.

(4) For initial licensure of a new nursing home, the proposed licensee must submit the annual license fee with the initial license application. The nonrefundable nursing home license fee is three hundred twenty seven dollars per bed per year.

(5) If any information submitted in the initial license application changes before the license is issued, the proposed licensee must submit a revised application containing the changed information.

(6) If a license application is pending for more than six months, the proposed licensee must submit a revised application containing current information about the proposed licensee or any other individuals or entities named in the application.

[Statutory Authority: RCW 18.51.050, 43.135.055, and 2010 c 37 § 206 (19)(a). 10-21-037, § 388-97-4160, filed 10/12/10, effective 10/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-4160, filed 9/24/08, effective 11/1/08.]

WAC 388-97-4180 Nursing home license renewal. (1) All nursing home licenses must be renewed annually.

(2) License renewals must be:

(a) Submitted at least thirty days prior to the license's expiration date on forms designated by the department;

(b) Signed by the current licensee; and

(c) Reviewed by the department in accordance with this chapter.

(3) The current licensee must provide all information on the license renewal form or other information requested by the department.

(4) The application for a nursing home license renewal must be made by the individual or entity currently licensed and responsible for the daily operation of the nursing home.

(5) The nursing home license renewal fee must be submitted at the time of renewal. The nonrefundable nursing home license renewal fee is three hundred twenty seven dollars per bed per year.

(6) In unusual circumstances, the department may issue an interim nursing home license for a period not to exceed three months. The current licensee must submit the prorated nursing home license fee for the period covered by the interim license. The annual date of license renewal does not change when an interim license is issued.

(7) A change of nursing home ownership does not change the date of license renewal and fee payment.

[Statutory Authority: RCW 18.51.050, 43.135.055, and 2010 c 37 § 206 (19)(a). 10-21-037, § 388-97-4180, filed 10/12/10, effective 10/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-4180, filed 9/24/08, effective 11/1/08.]

Chapter 388-101 WAC

CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS

WAC

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388-101-4350 Notice—Service complete.
388-101-4360 Notice—Proof of service.

WAC 388-101-3000 Definitions. "Abandonment" means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means:

(1) The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult;

(2) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish; and

(3) Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) **"Sexual abuse"** means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.

(b) **"Physical abuse"** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing and certification requirements, and includes restraints that are otherwise being used inappropriately.

(c) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a

vulnerable adult from family, friends, regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) **"Exploitation"** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

"Associated with the applicant" means any person listed on the application as a partner, officer, director, or majority owner of the applying entity, or who is the spouse or domestic partner of the applicant.

"Case manager" means the division of developmental disabilities case resource manager or social worker assigned to a client.

"Certification" means a process used by the department to determine if an applicant or service provider complies with the requirements of this chapter and is eligible to provide certified community residential services and support to clients.

"Chaperone agreement" means a plan or agreement that describes who will supervise a community protection program client when service provider staff is not present. This plan or agreement is negotiated with other agencies and individuals who support the client, including the client's legal representative and family.

"Chemical restraint" means the use of psychoactive medications for discipline or convenience and not prescribed to treat the client's medical symptoms.

"Client" means a person who has a developmental disability as defined in RCW 71A.10.020(3) and who also has been determined eligible to receive services by the division of developmental disabilities under chapter 71A.16 RCW. For purposes of informed consent and decision making requirements, the term "client" includes the client's legal representative to the extent of the representative's legal authority.

"Client services" means instruction and support services that service providers are responsible to provide as identified in the client's individual support plan.

"Crisis diversion" means temporary crisis residential services and supports provided to clients at risk of psychiatric hospitalization and authorized by the division of developmental disabilities.

"Crisis diversion bed services" means crisis diversion that is provided in a residence maintained by the service provider.

"Crisis diversion support services" means crisis diversion that is provided in the client's own home.

"Department" means the Washington state department of social and health services.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage other than the vulnerable adult's profit or advantage.

"Functional assessment" means a comprehensive evaluation of a client's challenging behavior(s). This evaluation is the basis for developing a positive behavior support plan.

"Group home" means a residence that is licensed as either a boarding home or an adult family home by the department under chapters 388-78A or 388-76 WAC. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider.

"Group training home" means a certified nonprofit residential facility that provides full-time care, treatment, training, and maintenance for clients, as defined under RCW 71A.22.020(2).

"Immediate" or **"immediately"** means within twenty-four hours for purposes of reporting abandonment, abuse, neglect, or financial exploitation of a vulnerable adult.

"Individual financial plan" means a plan describing how a client's funds will be managed when the service provider is responsible for managing any or all of the client's funds.

"Individual instruction and support plan" means a plan developed by the service provider and the client. The individual instruction and support plan:

(1) Uses the information and assessed needs documented in the individual support plan to identify areas the client would like to develop;

(2) Includes client goals for instruction and support that will be formally documented during the year; and

(3) Must contain or refer to other applicable support or service information that describes how the client's health and welfare needs are to be met (e.g. individual financial plan, positive behavior support plan, cross system crisis plan, individual support plan, individual written plan, client-specific instructions).

"Individual support plan" means a document that authorizes and identifies the division of developmental disabilities paid services to meet a client's assessed needs.

"Instruction" means goal oriented teaching that is designed for acquiring and enhancing skills.

"Instruction and support services staff" means long-term care workers of the service provider whose primary job function is the provision of instruction and support services to clients. Instruction and support services staff shall also include employees of the service provider whose primary job function is the supervision of instruction and support services staff. In addition, both applicants, prior to initial certification, and administrators, prior to assuming duties, who may provide instruction and support services to clients shall be considered instruction and support services staff for the purposes of the applicable training requirements of chapter 388-112 WAC.

"Legal representative" means a person's legal guardian, a person's limited guardian when the subject matter is within the scope of the limited guardianship, a person's attorney at law, a person's attorney in fact, or any other person who is authorized by law to act for another person.

"Managing client funds" means that the service provider:

(1) Has signing authority for the client;

(2) Disperses the client's funds; or

(3) Limits the client's access to funds by not allowing funds to be spent.

"Mechanical restraint" means a device or object, which the client cannot remove, applied to the client's body that restricts his/her free movement.

"Medication administration" means the direct application of a prescribed medication whether by injection, inha-

lation, ingestion, or other means, to the body of the client by an individual legally authorized to do so.

"Medication assistance" means assistance with self administration of medication rendered by a nonpractitioner to a client receiving certified community residential services and supports in accordance with chapter 69.41 RCW and chapter 246-888 WAC.

"Medication service" means any service provided by a certified community residential services and support provider related to medication administration or medication assistance provided through nurse delegation and medication assistance.

"Neglect" means:

(1) A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

(2) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

"Physical intervention" means the use of a manual technique intended to interrupt or stop a behavior from occurring. This includes using physical restraint to release or escape from a dangerous or potentially dangerous situation.

"Physical restraint" means physically holding or restraining all or part of a client's body in a way that restricts the client's free movement. This does not include briefly holding, without undue force, a client in order to calm him/her, or holding a client's hand to escort the client safely from one area to another.

"Psychoactive" means possessing the ability to alter mood, anxiety level, behavior, cognitive processes, or mental tension, usually applied to pharmacological agents.

"Psychoactive medications" means medications prescribed to improve or stabilize mood, mental status or behavior. Psychoactive medications include anti-psychotics/neuroleptics, atypical antipsychotics, antidepressants, stimulants, sedatives/hypnotics, and antimania and antianxiety drugs.

"Qualified professional" means a person with at least three years' experience working with individuals with developmental disabilities and as required by RCW 71A.12.220 (12).

"Restrictive procedure" means any procedure that restricts a client's freedom of movement, restricts access to client property, requires a client to do something which he/she does not want to do, or removes something the client owns or has earned.

"Risk assessment" means an assessment done by a qualified professional and as required by RCW 71A.12.230.

"Service provider" means a person or entity certified by the department who delivers services and supports to meet a client's identified needs. The term includes the state operated living alternative (SOLA) program.

"Support" means assistance a service provider gives a client based on needs identified in the individual support plan.

"Supported living" means instruction, supports, and services provided by service providers to clients living in homes that are owned, rented, or leased by the client or their legal representative.

"Treatment team" means the program participant and the group of people responsible for the development, implementation, and monitoring of the person's individualized supports and services. This group may include, but is not limited to, the case manager, therapist, the service provider, employment/day program provider, and the person's legal representative and/or family, provided the person consents to the family member's involvement.

"Vulnerable adult" includes a person:

(1) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(2) Found incapacitated under chapter 11.88 RCW; or

(3) Who has a developmental disability as defined under RCW 71A.10.020; or

(4) Admitted to any facility; or

(5) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or

(6) Receiving services from an individual provider.

"Willful" means the deliberate, or nonaccidental, action or inaction by an individual that he/she knew or reasonably should have known could cause a negative outcome, including harm, injury, pain, or anguish.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3000, filed 7/30/10, effective 1/1/11. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3000, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3050 Application for initial certification. (1) To apply for initial certification an applicant must submit to the department:

(a) A letter of intent that includes:

(i) Contact information;

(ii) Geographical area of service; and

(iii) Type of service provided, including group home, supported living, community protection, or group training home.

(b) A completed and signed application on forms designated by the department;

(c) All attachments specified in the application and any other information the department may request including but not limited to:

(i) Administrator resumes;

(ii) Statements of financial stability;

(iii) Professional references;

(iv) Relevant experiences and qualifications of the individual or agency;

(v) On or after January 1, 2011, a certificate of completion of the instruction and support services staff training required under chapter 388-112 WAC, if the applicant may provide instruction and support services to a client or may supervise staff who provide such services; and

(vi) Assurances the applicant will not discriminate against any client or employee.

(d) A copy of the license if applying for certification as a group home;

(e) The name of the administrator of the program; and

(f) The department background authorization form for:

(i) The applicant;

(ii) Anyone associated with the applicant; and

(iii) The individual or individuals designated to serve as administrator of the proposed program.

(2) The applicant must submit a revised application, if any information on the application changes before the initial certification is issued.

(3) The department will only process a completed application.

(4) Each person named in the application for initial certification is considered separately and jointly by the department.

(5) Based on the documentation received, the department will notify the applicant in writing regarding the department's certification decision.

(6) The applicant must comply with additional requirements identified in this chapter if intending to support community protection clients.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3050, filed 7/30/10, effective 1/1/11. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3050, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3060 Change of ownership. (1) To apply for a change of ownership, an applicant must submit an application and the required reports and documents to the department when there is a change of:

(a) The business entity ownership; or

(b) The form of legal organization.

(2) When applying for a change of ownership, an applicant may be required to provide any or all items listed in WAC 388-101-3050.

(3) For group homes, applicants must also meet the applicable change of ownership requirements found in:

(a) WAC 388-76-10105 for licensed adult family homes; or

(b) WAC 388-78A-2770 through 388-78A-2787 for licensed boarding homes.

(4) If the applicant is not a current service provider, the applicant must apply for initial certification.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3060, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3060, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3080 The department may deny—Application. The department may deny the application for initial certification or change of ownership if any person named in the application has:

(1) Shown a lack of the understanding, character, ability, or emotional stability that is necessary to meet the identified needs of vulnerable adults;

(2) Had a contract terminated or a certification or license revoked or denied by the department, or has been subjected to department enforcement actions;

(3) Had a contract terminated, or a certification or license revoked or denied in another state, or has been subjected to an enforcement action in another state;

(4) Obtained or attempted to obtain a license or certification by fraudulent means or misrepresentation;

(5) Relinquished or been denied a license or license renewal to operate a home or facility that was licensed for the care of children or vulnerable adults;

(6) Refused to permit authorized department representatives to interview clients or to have access to client records;

(7) Been convicted of a drug-related conviction within the past five years without evidence of rehabilitation, unless denial is required under WAC 388-06-0180(4); or

(8) Been convicted of an alcohol-related conviction within the past five years without evidence of rehabilitation.

(9) Been convicted of any felony that the department determines is reasonably related to the competency of the person to be involved in the ownership or operation of the service provider.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3080, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3080, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3090 The department must deny—Application. (1) The department must deny an application for initial certification or change of ownership if any person named in the application has:

(a) Been convicted of a crime listed under WAC 388-06-0170(1);

(b) Been convicted of a disqualifying crime under WAC 388-06-0180;

(c) Been found by a court in a criminal proceeding, a protection proceeding, or a civil damages lawsuit under chapter 74.34 RCW, to have abused, neglected, abandoned, or financially exploited a vulnerable adult;

(d) Been found to have abused, neglected, financially exploited, or abandoned a minor or vulnerable adult by a court of law or a disciplining authority, including the department of health. Examples of legal proceedings in which such findings could be made include juvenile court proceedings under chapter 13.34 RCW, domestic relations proceedings under Title 26 RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW;

(e) A substantiated finding of abuse or neglect of a child that is:

(i) Listed on the department's background check central unit (BCCU) report; or

(ii) Disclosed by the individual, except for findings made before December 1998; or

(f) A substantiated finding of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult that is:

(i) Listed on any registry, including the department's registry;

(ii) Listed on the department's background check central unit (BCCU) report; or

(iii) Disclosed by the individual, except for adult protective services findings made before October 2003.

(2) The department must deny an application for initial certification or change of ownership if any person named in the application has a pending charge for a crime that is disqualifying under this section.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3090, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3090, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3165 Access to certification evaluation report and plan of correction. The service provider must make the certification evaluation report and related plan of correction available to anyone upon request.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3165, filed 1/15/10, effective 2/15/10.]

WAC 388-101-3205 Liability insurance required. The service provider must:

(1) Obtain liability insurance upon certification and maintain the insurance as required in WAC 388-101-3206 and 388-101-3207; and

(2) Have evidence of liability insurance coverage available if requested by the department.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3205, filed 1/15/10, effective 2/15/10.]

WAC 388-101-3206 Liability insurance required—Commercial general liability insurance or business liability insurance coverage. The service provider must have commercial general liability insurance or business liability insurance that includes:

(1) Coverage for the acts and omissions of any employee and volunteer;

(2) Coverage for bodily injury, property damage, and contractual liability;

(3) Coverage for premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract; and

(4) Minimum limits of:

(a) Each occurrence—One million dollars;

(b) General aggregate—Two million dollars; and

(c) For community protection service providers—Three million dollars general aggregate.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3206, filed 1/15/10, effective 2/15/10.]

WAC 388-101-3207 Liability insurance required—Professional liability insurance coverage. If the service provider employs professional staff, the service provider must have professional liability insurance or errors and omissions insurance. The insurance must include:

(1) Coverage for losses caused by errors and omissions of the service provider, its employees, and volunteers; and

(2) Minimum limits of:

(a) Each occurrence—One million dollars; and

(b) General aggregate—Two million dollars.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3207, filed 1/15/10, effective 2/15/10.]

WAC 388-101-3220 Administrator responsibilities and training. (1) The service provider must ensure that the administrator delivers services to clients consistent with this chapter, and the department's residential services contract. This includes but is not limited to:

(a) Overseeing all aspects of staffing, such as recruitment, staff training, and performance reviews;

(b) Developing and maintaining policies and procedures that give staff direction to provide appropriate services and support as required by this chapter and the department contract; and

(c) Maintaining and securely storing client, personnel, and financial records.

(2) Before assuming duties, an administrator hired on or after January 1, 2011, must complete the instruction and support services staff training requirements under chapter 388-112 WAC if the administrator may provide instruction and support services to clients or may supervise instruction and support services staff.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3220, filed 7/30/10, effective 1/1/11. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3220, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3245 Background check—General. (1) Background checks conducted by the department and required in this chapter include but are not limited to:

(a) Washington state background checks including:

(i) Department and department of health findings; and

(ii) Criminal background check information from the Washington state patrol and Washington state courts; and

(b) After January 1, 2012, a national fingerprint-based check in accordance with RCW 74.39A.055.

(2) Nothing in this chapter should be interpreted as requiring the employment of a person against the better judgment of the service provider.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3245, filed 7/30/10, effective 1/1/11.]

WAC 388-101-3250 Background checks—Washington state. (1) Service providers must follow the background check requirements described in chapter 388-06 WAC and in this chapter. In the event of an inconsistency, this chapter applies. The service provider must also follow background check requirements under WAC 388-101-3253.

(2) The service provider must obtain background checks from the department for all administrators, employees, volunteers, students, and subcontractors who may have unsupervised access to clients.

(3) The service provider must not allow the following persons to have unsupervised access to clients until the service provider receives the department's background check results, verifying that the person does not have any convictions, pending criminal charges, or findings described in WAC 388-101-3090:

(a) Administrators;

(b) Employees;

(c) Volunteers or students; and

(d) Subcontractors.

(4) If the background check results show that the individual has a conviction, pending criminal charge, or finding that is not disqualifying under WAC 388-101-3090, then the service provider must conduct a character, suitability, and competence review as described in WAC 388-06-0190.

(5) The service provider must:

(a) Inform the person of the results of the background check;

(b) Inform the person that they may request a copy in writing of the results of the background check. If requested, a copy of the background check results must be provided within ten working days of the request;

(c) Notify the department and other appropriate licensing or certification agency of any person resigning or terminated as a result of having a conviction record.

(6) The service provider must renew the Washington state background check at least every thirty-six months and keep current background check results for each administrator, employee, volunteer, student, or subcontractor of a service provider.

(7) Licensed boarding homes or adult family homes must adhere to the current regulations in this chapter and in the applicable licensing laws.

(8) Service providers must prevent unsupervised access to clients by any administrator, employee, subcontractor, student, or volunteer who has a disqualifying conviction, pending criminal charge, or finding described in WAC 388-101-3090.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3250, filed 7/30/10, effective 1/1/11. Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3250, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3250, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3253 National fingerprint-based background checks—Required. In addition to background checks required under WAC 388-101-3250:

(1) After January 1, 2012, applicants for initial certification and applicants for change of ownership that are not current providers, must have a background check that includes a national fingerprint-based background check.

(2) The service provider must ensure that staff who provide instruction and support services to clients, and are hired on or after January 1, 2012, submit a background check that includes a national fingerprint-based background check.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3253, filed 7/30/10, effective 1/1/11.]

WAC 388-101-3255 Background checks—Provisional hire—Pending results. (1) Persons identified in WAC 388-101-3250(2) who are hired on or before January 1, 2012 and who have lived in Washington state less than three years, or who are otherwise required to complete a fingerprint-based background check, may be hired for a one hundred twenty-day provisional period when:

(a) The person is not disqualified based on the initial results of the background check from the department; and

(b) A national fingerprint-based background is pending.

(2) Persons identified in WAC 388-101-3250(2) who are hired after January 1, 2012, may be hired for a one hundred twenty-day provisional period when:

(a) The person is not disqualified based on the initial result of the background check from the department; and

(b) A national fingerprint-based background check is pending.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3255, filed 7/30/10, effective 1/1/11.]

WAC 388-101-3258 Training requirements for staff hired before January 1, 2011. The service provider must ensure that staff hired before January 1, 2011 have met the training requirements under WAC 388-101-3260 through 388-101-3300.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3258, filed 7/30/10, effective 1/1/11.]

WAC 388-101-3302 Certified community residential services and supports—General training requirements. (1) On or after January 1, 2011, the service provider must ensure the following instruction and support services staff meet the training requirements under chapter 388-112 WAC, including orientation and safety training, and basic training:

(a) Administrators, hired on or after the effective date, who may provide instruction and support services to clients or may supervise instruction and support services staff; and

(b) Instruction and support services staff including their supervisors, who are hired on or after the effective date.

(2) On or after January 1, 2011, applicants for initial certification and applicants for change of ownership that are not current providers, who may provide instruction and support services to clients or may supervise instruction and support services staff must meet the training requirements of chapter 388-112 WAC, including orientation and safety training, and basic training.

(3) Under RCW 18.88B.040 and chapter 246-980 WAC, certain persons including registered nurses, licensed practical nurses, certified nursing assistants or persons who are in an approved certified nursing assistant program are exempt from long-term care worker training requirements.

[Statutory Authority: RCW 71A.12.080, chapter 74.39A RCW. 10-16-084, § 388-101-3302, filed 7/30/10, effective 1/1/11.]

WAC 388-101-3372 Medical devices. (1) For purposes of this section the term "medical device" means any piece of medical equipment used to treat a client's assessed need.

(2) Use of some medical devices poses a safety risk for clients. Examples of medical devices with known safety risks are transfer poles, helmets, straps and belts on wheelchairs or beds, and bed side rails.

(3) Medical devices with known safety risks must not be used by the service provider:

(a) As a restraint; or

(b) For staff convenience.

(4) Before using medical devices with known safety risks for any client, the service provider must:

(a) Review the client's assessment to identify the client's need;

(b) Identify and implement interventions that might decrease the need for the use of a medical device;

(c) Document the use of less restrictive and less invasive options, successful or not;

(d) Provide the client and client's family or legal representative with information about the anticipated benefits and safety risks of using the device to enable them to make an informed decision about whether or not to use the device;

(e) Obtain a current physician's order that describes the medical necessity for use of the device and the anticipated duration of use; and

(f) Provide written instructions to staff regarding safe and proper use of the device.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3372, filed 1/15/10, effective 2/15/10.]

WAC 388-101-3520 Shared expenses and client related funds. (1) For purposes of this section "common household expenses" means costs for rent, shared food and household supplies, and utilities, including but not limited to

water, garbage, cable television/radio, telephone, and electricity.

(2) The service provider must ensure that common household expenses are shared equitably among all clients living in the household.

(3) If the service provider receives funds for the client from any source, the service provider must be able to show that all the funds received are:

(a) Given to the client or the client's legal representative;

(b) Deposited to the client's account; or

(c) Used only for the client.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-3520, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3520, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4010 Community protection—Treatment plan. The community protection service provider must implement the client's treatment plan as written by a qualified professional/therapist in accordance with any procedures published by the department.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4010, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4010, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4170 Mandated reporting policies and procedures. (1) The service provider must develop, train on and implement written policies and procedures for:

(a) Immediately reporting mandated reporting incidents to:

(i) The department and law enforcement;

(ii) Appropriate persons within the service provider's agency as designated by the service provider; and

(iii) The alleged victim's legal representative.

(b) Protecting clients;

(c) Preserving evidence when necessary; and

(d) Initiating an outside review or investigation.

(2) The service provider must not have or implement any policies or procedures that interfere with a mandated reporter's obligation to report.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4170, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4170, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4269 Individual defined. As used in WAC 388-101-4270 through 388-101-4340, the term "individual" means anyone used by the service provider to provide services to clients who is alleged to have abandoned, abused, neglected, or financially exploited a client. "Individual" includes but is not limited to administrators, employees, contractors, subcontractors, volunteers, and students.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4269, filed 1/15/10, effective 2/15/10.]

WAC 388-101-4270 Notice to individual of preliminary findings. (1) The department will serve notice of the preliminary finding as provided in WAC 388-101-4350.

(2) The department may establish proof of service as provided in WAC 388-101-4360.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4270, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4270, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4280 Notice to others of preliminary findings. Consistent with confidentiality requirements concerning the client, witnesses, and reporter, the department may provide notification of a preliminary finding to:

(1) Other divisions within the department;

(2) The agency or program identified under RCW 74.34.068 with which the individual was associated as an employee, volunteer or contractor;

(3) The employer or program that is currently associated with the individual;

(4) Law enforcement;

(5) Other entities as authorized by law and this chapter including investigative authorities consistent with chapter 74.34 RCW; and

(6) The appropriate licensing agency.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4280, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4280, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4290 Disputing a preliminary finding. (1) An individual may request an administrative hearing to challenge a preliminary finding made by the department.

(2) The request must be made in writing to the office of administrative hearings.

(3) The office of administrative hearings must receive the individual's written request for a hearing within thirty calendar days of the date written on the notice of the preliminary finding.

(4) The written request for a hearing must include:

(a) The full legal name, current address and phone number of the individual;

(b) A brief explanation of why the individual disagrees with the preliminary finding;

(c) A description of any assistance needed in the administrative appeal process by the individual, including a foreign language or sign language interpreter or any reasonable accommodation for a disability; and

(d) The individual's signature.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4290, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4290, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4300 Disclosure of investigative and finding information. (1) Confidential information about clients and mandated reporters received from the department may only be used by the individual to challenge findings through the appeal process. It may only be shared with persons who are involved in the appeal.

(2) Confidential information such as the name and other personal identifying information of the reporter, witnesses, or the client will be redacted from documents unless release of that information is consistent with chapter 74.34 RCW and other applicable state and federal laws.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4300, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4300, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4310 Hearing procedures to dispute a preliminary finding. (1) Chapters 34.05 and 74.34 RCW, chapter 388-02 WAC, and the provisions of this chapter govern any appeal regarding a preliminary finding. In the event

of a conflict between the provisions of this chapter and chapter 388-02 WAC, the provisions of this chapter shall prevail.

(2) The administrative law judge shall determine whether the preliminary finding is supported by a preponderance of the evidence.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4310, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4310, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4320 Appeal of the initial order. (1) If the individual or the department disagrees with the administrative law judge's decision, either party may challenge this decision by filing a petition for review with the department's board of appeals under chapters 34.05 RCW and 388-02 WAC.

(2) If the department appeals the administrative law judge's decision, the department will not modify the finding in the department's records until a final hearing decision is issued.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4320, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4320, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4330 Finalizing a preliminary finding. (1) A preliminary finding becomes a final finding when:

(a) The department gives the individual notice of the preliminary finding under WAC 388-101-4270 and the individual does not request an administrative hearing;

(b) The administrative law judge:

(i) Dismisses the appeal following withdrawal of the appeal or default; or

(ii) Issues an initial order upholding the finding and the individual fails to appeal the initial order to the department's board of appeals; or

(c) The board of appeals issues a final order upholding the finding.

(2) The final finding is permanent and will only be removed from the department's records if it is rescinded following judicial review.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4330, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4330, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4340 Reporting final findings. (1) The department will report a final finding of abandonment, abuse, neglect, or financial exploitation within ten working days to the following:

(a) The individual against whom the final finding was made;

(b) The service provider that was associated with the individual during the time of the incident;

(c) The service provider that is currently associated with the individual against whom the final finding was made, if known;

(d) The appropriate licensing, contracting, or certification authority; and

(e) Any federal or state registry or list of individuals found to have abandoned, abused, neglected, or financially exploited a vulnerable adult.

(2) The findings may be disclosed to the public upon request subject to applicable public disclosure laws.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4340, filed 1/15/10, effective 2/15/10. Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4340, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4350 Notice—Service complete. Service of the department notices is complete when:

(1) Personal service is made;

(2) The notice is addressed to the service provider or to the individual at his or her last known address, and deposited in the United States mail;

(3) The notice is faxed and the department receives evidence of transmission;

(4) Notice is delivered to a commercial delivery service with charges prepaid; or

(5) Notice is delivered to a legal messenger service with charges prepaid.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4350, filed 1/15/10, effective 2/15/10.]

WAC 388-101-4360 Notice—Proof of service. The department may establish proof of service by any of the following:

(1) A declaration of personal service;

(2) An affidavit or certificate of mailing to the service provider or to the individual to whom the notice is directed;

(3) A signed receipt from the person who accepted the certified mail, the commercial delivery service, or the legal messenger service package; or

(4) Proof of fax transmission.

[Statutory Authority: RCW 71A.12.080. 10-03-065, § 388-101-4360, filed 1/15/10, effective 2/15/10.]

Chapter 388-105 WAC

MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES

WAC

388-105-0005 The daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services.

WAC 388-105-0005 The daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services. For contracted AFH and boarding homes contracted to provide AL, ARC, and EARC services, the department pays the following daily rates for care of a medicaid resident:

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE
KING COUNTY

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$66.65	$72.07	$47.19	$47.19	$46.39
A Med	$72.15	$77.57	$53.52	$53.52	$52.64
A High	$80.94	$86.36	$58.76	$58.76	$58.90
B Low	$66.65	$72.07	$47.19	$47.19	$46.62
B Med	$74.35	$79.77	$59.85	$59.85	$59.19
B Med-High	$84.18	$89.60	$63.63	$63.63	$63.42
B High	$88.61	$94.03	$72.71	$72.71	$72.51
C Low	$72.15	$77.57	$53.52	$53.52	$52.64
C Med	$80.94	$86.36	$67.13	$67.13	$67.22
C Med-High	$100.71	$106.13	$89.42	$89.42	$88.06
C High	$101.71	$107.13	$90.27	$90.27	$89.29
D Low	$74.35	$79.77	$72.27	$72.27	$68.52
D Med	$82.59	$88.01	$83.70	$83.70	$83.87
D Med-High	$106.74	$112.16	$106.39	$106.39	$100.92
D High	$115.01	$120.43	$115.01	$115.01	$114.90
E Med	$138.95	$144.37	$138.95	$138.95	$138.84
E High	$162.89	$168.31	$162.89	$162.89	$162.79

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE
METROPOLITAN COUNTIES*

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$61.15	$66.07	$47.19	$47.19	$46.39
A Med	$64.46	$69.38	$51.41	$51.41	$50.55
A High	$78.74	$83.66	$56.04	$56.04	$55.76
B Low	$61.15	$66.07	$47.19	$47.19	$46.62
B Med	$69.94	$74.86	$56.69	$56.69	$56.04
B Med-High	$79.20	$84.12	$60.27	$60.27	$60.10
B High	$86.42	$91.34	$70.66	$70.66	$70.46
C Low	$64.46	$69.38	$51.62	$51.62	$50.93
C Med	$78.74	$83.66	$66.27	$66.27	$65.58
C Med-High	$97.40	$102.32	$83.09	$83.09	$81.82
C High	$98.37	$103.29	$88.37	$88.37	$86.81
D Low	$69.94	$74.86	$71.28	$71.28	$67.01
D Med	$80.34	$85.26	$82.03	$82.03	$81.61
D Med-High	$103.24	$108.16	$103.76	$103.76	$97.84
D High	$111.85	$116.77	$111.85	$111.85	$111.16
E Med	$134.64	$139.56	$134.64	$134.64	$133.95
E High	$157.43	$162.35	$157.43	$157.43	$156.74

*Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties.

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE
NONMETROPOLITAN COUNTIES**

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$60.07	$65.31	$47.19	$47.19	$46.39
A Med	$64.46	$69.70	$50.36	$50.36	$49.52
A High	$78.74	$83.98	$55.14	$55.14	$54.73

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
B Low	$60.07	$65.31	$47.19	$47.19	$46.62
B Med	$69.94	$75.18	$55.64	$55.64	$55.00
B Med-High	$79.20	$84.44	$59.14	$59.14	$58.92
B High	$86.42	$91.66	$66.84	$66.84	$66.64
C Low	$64.46	$69.70	$50.36	$50.36	$49.52
C Med	$78.74	$83.98	$62.65	$62.65	$63.07
C Med-High	$97.40	$102.64	$79.92	$79.92	$78.70
C High	$98.37	$103.61	$83.54	$83.54	$82.10
D Low	$69.94	$75.18	$67.39	$67.39	$63.37
D Med	$80.34	$85.58	$77.55	$77.55	$77.17
D Med-High	$103.24	$108.48	$98.08	$98.08	$92.52
D High	$105.73	$110.97	$105.73	$105.73	$105.10
E Med	$127.27	$132.51	$127.27	$127.27	$126.64
E High	$148.81	$154.05	$148.81	$148.81	$148.19

** Nonmetropolitan counties: Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Garfield, Grant, Grays Harbor, Jefferson, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Orielle, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla and Whitman.

[Statutory Authority: RCW 74.39A.030(3) and 2010 c 37 § 206 (19)(a). 10-21-035, § 388-105-0005, filed 10/12/10, effective 10/29/10. Statutory Authority: RCW 74.39A.030(3), 18.20.290, and 2009 c 564 § 206(4). 09-20-011, § 388-105-0005, filed 9/25/09, effective 10/26/09. Statutory Authority: RCW 74.39A.030 (3)(a). 09-11-053, § 388-105-0005, filed 5/13/09, effective 6/13/09. Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. 06-19-017, § 388-105-0005, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. 06-07-013, § 388-105-0005, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.39A.030, 2003 c 231. 04-09-092, § 388-105-0005, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. 02-22-058, § 388-105-0005, filed 10/31/02, effective 12/1/02. Statutory Authority: 2001 c 7 § 206. 01-21-077, § 388-105-0005, filed 10/18/01, effective 11/18/01. Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0005, filed 6/29/01, effective 7/30/01.]

Chapter 388-106 WAC
LONG-TERM CARE SERVICES

WAC

388-106-0010 What definitions apply to this chapter?
388-106-0125 If I am age twenty-one or older, how does CARE use criteria to place me in a classification group for in-home care?
388-106-0126 If I am under age twenty-one, how does CARE use criteria to place me in a classification group for in-home care?
388-106-1303 What responsibilities do I have as a client of the department?
388-106-1400 What services may I receive under New Freedom consumer directed services (NFCDS)?
388-106-1405 What services are not covered under New Freedom consumer directed services (NFCDS)?
388-106-1422 What happens to my New Freedom service dollar budget if I am temporarily hospitalized, placed in a nursing facility or intermediate care facilities for the mentally retarded (ICF/MR)?
388-106-1435 Who can direct New Freedom consumer directed services (NFCDS)?
388-106-1445 How is the amount of the individual budget determined?
388-106-1455 What happens to unused funds from my individual budget?

WAC 388-106-0010 What definitions apply to this chapter? "Ability to make self understood" means how you make yourself understood to those closest to you; express or communicate requests, needs, opinions, urgent problems and social conversations, whether in speech, writing, sign language, symbols, or a combination of these including use of a communication board or keyboard:

(a) Understood: You express ideas clearly;

(b) Usually understood: You have difficulty finding the right words or finishing thoughts, resulting in delayed responses, or you require some prompting to make self understood;

(c) Sometimes understood: You have limited ability, but are able to express concrete requests regarding at least basic needs (e.g. food, drink, sleep, toilet);

(d) Rarely/never understood. At best, understanding is limited to caregiver's interpretation of client specific sounds or body language (e.g. indicated presence of pain or need to toilet.)

"Activities of daily living (ADL)" means the following:

(a) Bathing: How you take a full-body bath/shower, sponge bath, and transfer in/out of tub/shower.

(b) Bed mobility: How you move to and from a lying position, turn side to side, and position your body while in bed, in a recliner, or other type of furniture.

(c) Body care: How you perform with passive range of motion, applications of dressings and ointments or lotions to the body and pedicure to trim toenails and apply lotion to feet. In adult family homes, contracted assisted living, enhanced adult residential care, and enhanced adult residential care-specialized dementia care facilities, dressing changes using clean technique and topical ointments must be performed by a licensed nurse or through nurse delegation in accordance with chapter 246-840 WAC. Body care excludes:

(i) Foot care if you are diabetic or have poor circulation; or

(ii) Changing bandages or dressings when sterile procedures are required.

(d) Dressing: How you put on, fasten, and take off all items of clothing, including donning/removing prosthesis.

(e) Eating: How you eat and drink, regardless of skill. Eating includes any method of receiving nutrition, e.g., by mouth, tube or through a vein.

(f) Locomotion in room and immediate living environment: How you move between locations in your room and immediate living environment. If you are in a wheelchair, locomotion includes how self-sufficient you are once in your wheelchair.

(g) Locomotion outside of immediate living environment including outdoors: How you move to and return from more distant areas. If you are living in a boarding home or nursing facility (NF), this includes areas set aside for dining, activities, etc. If you are living in your own home or in an adult family home, locomotion outside immediate living environment including outdoors, includes how you move to and return from a patio or porch, backyard, to the mailbox, to see the next-door neighbor, etc.

(h) Walk in room, hallway and rest of immediate living environment: How you walk between locations in your room and immediate living environment.

(i) Medication management: Describes the amount of assistance, if any, required to receive medications, over the counter preparations or herbal supplements.

(j) Toilet use: How you use the toilet room, commode, bedpan, or urinal, transfer on/off toilet, cleanse, change pad, manage ostomy or catheter, and adjust clothes.

(k) Transfer: How you move between surfaces, i.e., to/from bed, chair, wheelchair, standing position. Transfer does not include how you move to/from the bath, toilet, or vehicle.

(l) Personal hygiene: How you maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands (including nail care), and perineum (menses care). Personal hygiene does not include hygiene in baths and showers.

"Aged person" means a person sixty-five years of age or older.

"Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to you in your own home.

"Application" means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant must submit the request on a form prescribed by the department.

"Assessment details" means a summary of information that the department entered into the CARE assessment describing your needs.

"Assessment or reassessment" means an inventory and evaluation of abilities and needs based on an in-person interview in your own home or your place of residence, using CARE.

"Assistance available" means the amount of informal support available if the need is partially met. The department determines the amount of the assistance available using one of four categories:

(a) Less than one-fourth of the time;

(b) One-fourth to one-half of the time;

(c) Over one-half of the time to three-fourths of the time; or

(d) Over three-fourths but not all of the time.

"Assistance with body care" means you need assistance with:

(a) Application of ointment or lotions;

(b) Trimming of toenails;

(c) Dry bandage changes; or

(d) Passive range of motion treatment.

"Assistance with medication management" means you need assistance managing your medications. You are scored as:

(a) Independent if you remember to take medications as prescribed and manage your medications without assistance.

(b) Assistance required if you need assistance from a nonlicensed provider to facilitate your self-administration of a prescribed, over the counter, or herbal medication, as defined in chapter 246-888 WAC. Assistance required includes reminding or coaching you, handing you the medication container, opening the container, using an enabler to assist you in getting the medication into your mouth, alteration of a medication for self-administration, and placing the medication in your hand. This does not include assistance with intravenous or injectable medications. You must be aware that you are taking medications.

(c) Self-directed medication assistance/administration if you are a person with a functional disability who is capable of and who chooses to self-direct your medication assistance/administration.

(d) Must be administered if you must have medications placed in your mouth or applied or instilled to your skin or mucus membrane. Administration must either be performed by a licensed professional or delegated by a registered nurse to a qualified caregiver (per chapter 246-840 WAC). Intravenous or injectable medications may never be delegated. Administration may also be performed by a family member or unpaid caregiver if facility licensing regulations allow.

"Authorization" means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

"Blind person" means a person determined blind as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-475-0100 and chapter 388-513 WAC.

"Client" means an applicant for service or a person currently receiving services from the department.

"Current" means a behavior occurred within seven days of the CARE assessment date, including the day of the assessment. Behaviors that the department designates as current must include information about:

(a) Whether the behavior is easily altered or not easily altered; and

(b) The frequency of the behavior.

"Decision making" means your ability and actual performance in making everyday decisions about tasks or activ-

ities of daily living. The department determines whether you are:

(a) Independent: Decisions about your daily routine are consistent and organized; reflecting your lifestyle, choices, culture, and values.

(b) Modified independence/difficulty in new situations: You have an organized daily routine, are able to make decisions in familiar situations, but experience some difficulty in decision making when faced with new tasks or situations.

(c) Moderately impaired/poor decisions; unaware of consequences: Your decisions are poor and you require reminders, cues and supervision in planning, organizing and correcting daily routines. You attempt to make decisions, although poorly.

(d) Severely impaired/no or few decisions: Decision making is severely impaired; you never/rarely make decisions.

"Department" means the state department of social and health services, aging and disability services administration or its designee.

"Designee" means area agency on aging.

"Difficulty" means how difficult it is or would be for you to perform an instrumental activity of daily living (IADL). This is assessed as:

(a) No difficulty in performing the activity;

(b) Some difficulty in performing the activity (e.g., you need some help, are very slow, or fatigue easily); or

(c) Great difficulty in performing the activity (e.g., little or no involvement in the activity is possible).

"Disabling condition" means you have a medical condition which prevents you from self performance of personal care tasks without assistance.

"Estate recovery" means the department's process of recouping the cost of medicaid and long-term care benefit payments from the estate of the deceased client. See chapter 388-527 WAC.

"Home health agency" means a licensed:

(a) Agency or organization certified under medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(b) Home health agency, certified or not certified under medicare, contracted and authorized to provide:

(i) Private duty nursing; or

(ii) Skilled nursing services under an approved medicaid waiver program.

"Income" means income as defined under WAC 388-500-0005.

"Individual provider" means a person employed by you to provide personal care services in your own home. See WAC 388-71-0500 through 388-71-05909.

"Disability" is described under WAC 388-511-1105.

"Informal support" means a person or resource that is available to provide assistance without home and community program funding. The person or resource providing the informal support must be age 18 or older.

"Institution" means medical facilities, nursing facilities, and institutions for the mentally retarded. It does not include correctional institutions. See medical institutions in WAC 388-500-0005.

"Instrumental activities of daily living (IADL)" means routine activities performed around the home or in the community and includes the following:

(a) Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food, utensils, and cleaning up after meals). NOTE: The department will not authorize this IADL to plan meals or clean up after meals. You must need assistance with actual meal preparation.

(b) Ordinary housework: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).

(c) Essential shopping: How shopping is completed to meet your health and nutritional needs (e.g., selecting items). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities and household items required specifically for your health, maintenance or well-being. This includes shopping with or for you.

(d) Wood supply: How wood is supplied (e.g., splitting, stacking, or carrying wood) when you use wood as the sole source of fuel for heating and/or cooking.

(e) Travel to medical services: How you travel by vehicle to a physician's office or clinic in the local area to obtain medical diagnosis or treatment-includes driving vehicle yourself, traveling as a passenger in a car, bus, or taxi.

(f) Managing finances: How bills are paid, checkbook is balanced, household expenses are managed. The department cannot pay for any assistance with managing finances.

(g) Telephone use: How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

"Long-term care services" means the services administered directly or through contract by the aging and disability services administration and identified in WAC 388-106-0015.

"Medicaid" is defined under WAC 388-500-0005.

"Medically necessary" is defined under WAC 388-500-0005.

"Medically needy (MN)" means the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"New Freedom consumer directed services (NFCDS)" means a mix of services and supports to meet needs identified in your assessment and identified in a New Freedom spending plan, within the limits of the individual budget, that provide you with flexibility to plan, select, and direct the purchase of goods and services to meet identified needs. Participants have a meaningful leadership role in:

(a) The design, delivery and evaluation of services and supports;

(b) Exercising control of decisions and resources, making their own decisions about health and well being;

(c) Determining how to meet their own needs;

(d) Determining how and by whom these needs should be met; and

(e) Monitoring the quality of services received.

"New Freedom consumer directed services (NFCDS) participant" means a participant who is an applicant for or currently receiving services under the NFCDS waiver.

"New Freedom spending plan (NFSP)" means the plan developed by you, as a New Freedom participant, within the limits of an individual budget, that details your choices to purchase specific NFCDS and provides required federal medicaid documentation.

"Own home" means your present or intended place of residence:

(a) In a building that you rent and the rental is not contingent upon the purchase of personal care services as defined in this section;

(b) In a building that you own;

(c) In a relative's established residence; or

(d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

"Past" means the behavior occurred from eight days to five years of the assessment date. For behaviors indicated as past, the department determines whether the behavior is addressed with current interventions or whether no interventions are in place.

"Personal aide" is defined in RCW 74.39.007.

"Personal care services" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices.

"Physician" is defined under WAC 388-500-0005.

"Plan of care" means assessment details and service summary generated by CARE.

"Provider or provider of service" means an institution, agency, or person:

(a) Having a signed department contract to provide long-term care client services; and

(b) Qualified and eligible to receive department payment.

"Reasonable cost" means a cost for a service or item that is consistent with the market standards for comparable services or items.

"Representative" means a person who you have chosen, or has been appointed by a court, whose primary duty is to act on your behalf to direct your service budget to meet your identified health, safety, and welfare needs.

"Residential facility" means a licensed adult family home under department contract or licensed boarding home under department contract to provide assisted living, adult residential care or enhanced adult residential care.

"Self performance for ADLs" means what you actually did in the last seven days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period and does not include support provided as defined in WAC 388-106-0010. Your self performance level is scored as:

(a) Independent if you received no help or oversight, or if you needed help or oversight only once or twice;

(b) Supervision if you received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if you were highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if you performed part of the activity, but on three or more occasions, you needed weight bearing support or you received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means you needed physical help with part of the activity (other than transfer);

(e) Total dependence if you received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by you in all aspects of the ADL; or

(f) Activity did not occur if you or others did not perform an ADL over the last seven days before your assessment. The activity may not have occurred because:

(i) You were not able (e.g., walking, if paralyzed);

(ii) No provider was available to assist; or

(iii) You declined assistance with the task.

"Self performance for IADLs" means what you actually did in the last thirty days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the thirty-day period. Your self performance is scored as:

(a) Independent if you received no help, set-up help, or supervision;

(b) Set-up help/arrangements only if on some occasions you did your own set-up/arrangement and at other times you received help from another person;

(c) Limited assistance if on some occasions you did not need any assistance but at other times in the last thirty days you required some assistance;

(d) Extensive assistance if you were involved in performing the activity, but required cueing/supervision or partial assistance at all times;

(e) Total dependence if you needed the activity fully performed by others; or

(f) Activity did not occur if you or others did not perform the activity in the last thirty days before the assessment.

"Service summary" is CARE information which includes: Contacts (e.g. emergency contact), services the client is eligible for, number of hours or residential rates, personal care needs, the list of formal and informal providers and what tasks they will provide, a provider schedule, referral needs/information, and dates and agreement to the services.

"SSI-related" is defined under WAC 388-475-0050.

"Status" means the amount of informal support available. The department determines whether the ADL or IADL is:

(a) Met, which means the ADL or IADL will be fully provided by an informal support;

(b) Unmet, which means an informal support will not be available to provide assistance with the identified ADL or IADL;

(c) Partially met, which means an informal support will be available to provide some assistance, but not all, with the identified ADL or IADL; or

(d) Client declines, which means you do not want assistance with the task.

"Supplemental Security Income (SSI)" means the federal program as described under WAC 388-500-0005.

"Support provided" means the highest level of support provided (to you) by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing you with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

"You/your" means the client.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-0010, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.-090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0010, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0010, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0010, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0125 If I am age twenty-one or older, how does CARE use criteria to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLS as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a classification path of highest possible base hours to lowest qualifying base hours.

(1) If you meet the criteria for exceptional care, then CARE will place you in **Group E.** CARE then further classifies you into:

(a) **Group E High** with 416 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with 346 base hours if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have cognitive performance score of 4-6 or you have cognitive performance score of 5-6, then you are classified in **Group D** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group D High** with 277 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with 234 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with 185 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with 138 base hours if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in **Group C** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group C High** with 194 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with 174 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with 132 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with 87 base hours if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into **Group B.** CARE further classifies you into:

(a) **Group B High** with 147 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with 82 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with 47 base hours if you have an ADL score of 0-4; or

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in **Group B.** CARE further classifies you into:

(a) **Group B High** with 147 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with 101 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with 82 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with 47 base hours if you have a behavior point score greater than 1.

(6) If you are not clinically complex and your CPS score is less than 5 and you do not qualify under either mood and behavior criteria, then you are classified in **Group A.** CARE further classifies you into:

(a) **Group A High** with 71 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with 56 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with 26 base hours if you have an ADL score of 0-4.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 564 § 206(5). 10-11-050, § 388-106-0125, filed 5/12/10, effective 6/12/10. Statutory Authority: RCW 74.08.090, 74.09.520, and 2007 c 522. 08-10-022, § 388-106-0125, filed 4/25/08, effective 5/26/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0125, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0126 If I am under age twenty-one, how does CARE use criteria to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLS as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a

classification path of highest possible base hours to lowest qualifying base hours.

(1) If you meet the criteria for exceptional care, then CARE will place you in **Group E.** CARE then further classifies you into:

(a) **Group E High** with 420 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with 350 base hours if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have cognitive performance score of 4-6 or you have cognitive performance score of 5-6, then you are classified in **Group D** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group D High** with 280 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with 240 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with 190 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with 145 base hours if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in **Group C** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group C High** with 200 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with 180 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with 140 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with 95 base hours if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into **Group B.** CARE further classifies you into:

(a) **Group B High** with 155 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with 90 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with 52 base hours if you have an ADL score of 0-4; or

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in **Group B.** CARE further classifies you into:

(a) **Group B High** with 155 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with 110 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with 90 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with 52 base hours if you have a behavior point score greater than 1.

(6) If you are not clinically complex and your CPS score is less than 5 and you do not qualify under either mood and behavior criteria, then you are classified in **Group A.** CARE further classifies you into:

(a) **Group A High** with 78 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with 62 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with 29 base hours if you have an ADL score of 0-4.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 564 § 206(5). 10-11-050, § 388-106-0126, filed 5/12/10, effective 6/12/10.]

WAC 388-106-1303 What responsibilities do I have as a client of the department? As a client of the department, you have a responsibility to:

(1) Give us enough information to assess your needs;

(2) Let the social services worker into your home so that your needs can be assessed;

(3) Follow your care plan;

(4) Not act in a way that puts anyone in danger;

(5) Provide a safe work place;

(6) Tell your social services worker if there is a change in:

(a) Your medical condition;

(b) The help you get from family or other agencies;

(c) Where you live; or

(d) Your financial situation.

(7) Tell your social services worker if someone else makes medical or financial decision for you;

(8) Choose a qualified provider;

(9) Inform the department and your home care agency if an employee assigned by the home care agency is related to you by blood, marriage, adoption, or registered domestic partnership.

(10) Keep provider background checks private;

(11) Tell your social services worker if you are having problems with your provider; and

(12) Choose your own health care. Tell your social services worker when you do not do what your doctor says.

[Statutory Authority: RCW 74.08.090, 74.09.520, 2009 c 571, and Washington state 2009-11 budget, section 206(17). 10-06-112, § 388-106-1303, filed 3/3/10, effective 4/3/10. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-1303, filed 2/6/06, effective 3/9/06.]

WAC 388-106-1400 What services may I receive under New Freedom consumer directed services (NFCDS)? (1) In order for services, supports, and/or items to be purchased under New Freedom, they must:

(a) Be for your sole benefit;

(b) Be at a reasonable cost;

(c) Meet your identified needs and outcomes in the CARE assessment and address your health, safety, and welfare; and

(d) Be documented on your New Freedom spending plan.

(2) Your consultant may require a physician or other licensed professional, such as an occupational or physical therapist to recommend a specific purchase in writing. This recommendation is needed to ensure the service, support and/or item will increase, maintain, or delay decline of functional abilities, and to ensure the purchase supports your health and welfare.

(3) You may use your individual budget to purchase services, supports, and/or items that fall into the following service categories:

(a) **Personal assistance services,** defined as supports involving the labor of another person to assist you to carry out activities you are unable to perform independently. Services may be provided in your home or in the community and may include:

(i) Direct personal care services defined as assistance with activities of daily living, as defined in WAC 388-106-0010;

(ii) Delegated nursing tasks, per WAC 246-841-405 and 388-71-05830. Providers of direct personal care services may be delegated by a registered nurse to provide nurse delegated tasks according to RCW 18.79.260 and WAC 246-840-910 through 246-840-970;

(iii) Homemaking, or assistance with instrumental activities of daily living (essential shopping, housework and meal preparation);

(iv) Other tasks or assistance with activities that support independent functioning, and are necessary due to your functional disability;

(v) Personal assistance with transportation.

(b) **Treatment and health maintenance,** defined as treatments or activities that are beyond the scope of the medicaid state plan that are necessary to promote your health and ability to live independently in the community and:

(i) Are provided for the purpose of preventing further deterioration of your level of functioning, or improving or maintaining your current level of functioning; and

(ii) Are performed or provided by people with specialized skill, registration, certification or licenses as required by state law.

(c) **Individual directed goods, services and supports,** defined as services, equipment or supplies not otherwise provided through this waiver or through the medicaid state plan; and

(i) Will allow you to function more independently; or

(ii) Increase your safety and welfare; or

(iii) Allow you to perceive, control, or communicate with your environment.

(d) **Environmental or vehicle modifications,** defined as alterations to your residence or vehicle that are necessary to accommodate your disability and promote your functional independence, health, safety, and/or welfare.

(i) Environmental modifications cannot be adaptations or improvements that are of general utility or merely add to the total square footage of the home.

(ii) Vehicles subject to modification must be owned by you or a member of your family who resides with you; must be in good working condition, licensed, and insured according to Washington state law; and be cost effective when compared to available alternative transportation.

(e) **Training and educational supports,** defined as supports beyond the scope of medicaid state plan services that are necessary to promote your health and ability to live and participate in the community and maintains, slows decline, or improves functioning and adaptive skills. Examples include:

(i) Training or education on your health issues, or personal skill development;

(ii) Training or education to paid or unpaid caregivers related to your needs.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1400, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.-090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1400, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1405 What services are not covered under New Freedom consumer directed services (NFCDS)? Services, supports and/or items that cannot be purchased within New Freedom budgets, including, but not limited to:

(1) Services, supports and/or items covered by the state plan, medicare, or other programs or services.

(2) Any fees related to health or long-term care incurred by you, including co-pays, waiver cost of care (participation), or insurance.

(3) Home modifications that merely add square footage to your home.

(4) Vacation expenses other than the direct cost of provision of personal care services while on vacation (but you may not use New Freedom funds to pay travel expenses for your provider).

(5) Rent or room and board.

(6) Tobacco or alcohol products;

(7) Lottery tickets.

(8) Entertainment items such as television, cable, or DVD players.

(9) Vehicle purchases, maintenance or upgrades that do not include maintenance to modifications related to disability.

(10) Tickets and related costs to attend sporting or other recreational events.

(11) Routine household supplies and maintenance, basic food, clothing, and major household appliances.

(12) Pets and their related costs.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1405, filed 4/6/10, effective 5/7/10.]

WAC 388-106-1422 What happens to my New Freedom service dollar budget if I am temporarily hospitalized, placed in a nursing facility or intermediate care facilities for the mentally retarded (ICF/MR)? If you are admitted to a hospital, nursing home or ICF/MR, you cannot access your New Freedom service budget during your stay.

If you are institutionalized for forty-five days or less and you intend to return to New Freedom when discharged, your service budget will be suspended. Upon discharge home, your service budget will be reinstated.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1422, filed 4/6/10, effective 5/7/10.]

WAC 388-106-1435 Who can direct New Freedom consumer directed services (NFCDS)? You, as an NFCDS participant, direct your services. You may also designate, or a court may appoint, a representative to assist you in directing your services, or to direct your services on your behalf. A New Freedom designated representative cannot also be your paid provider.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1435, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.-

090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1435, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1445 How is the amount of the individual budget determined? The department will calculate your individual budget amount after you are assigned a classification resulting from completion of the comprehensive assessment reporting and evaluation tool, CARE. The calculation will be based on:

(a) The hourly wage as determined by the collective bargaining agreement for individual provider personal care paid by the department multiplied by the number of hours generated by the assessment, multiplied by a factor of .95, plus an amount equal to the average per participant expenditures for nonpersonal care supports purchased in the COPES waiver. The average will be recalculated in July of each year.

(b) If you select a home care agency, an adjustment will be made for each hour of personal care identified in the NFSP for an amount equal to the difference between the published individual provider rate and home care agency rate.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1445, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.-090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1445, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1455 What happens to unused funds from my individual budget? (1) Unused funds, up to three thousand dollars, may be held in reserve for future purchases documented in the NFSP. Reserves in excess of three thousand dollars may be maintained for planned purchases with approval from the department.

(2) Unused funds, up to five hundred dollars, may be held in reserve for future purchases not yet identified as planned purchases in their NFSP.

(3) Unused funds will revert back to the department under the following circumstances:

(a) You have funds over five hundred dollars that are not identified for planned purchases in your NFSP;

(b) You disenroll from New Freedom;

(c) You lose eligibility for New Freedom;

(d) You are hospitalized and/or placed in a nursing home or ICM/FR for over forty-five days; or

(e) You have reserved funds in excess of three thousand dollars held in reserve for future purchases not approved by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 10-08-074, § 388-106-1455, filed 4/6/10, effective 5/7/10. Statutory Authority: RCW 74.08.-090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1455, filed 7/25/06, effective 8/25/06.]

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WORKFIRST

WAC

388-310-0100 WorkFirst—Purpose.
388-310-0200 WorkFirst—Activities.
388-310-0350 WorkFirst—Other exemptions from mandatory participation.
388-310-0400 WorkFirst—Entering the WorkFirst program as a mandatory participant.
388-310-0800 WorkFirst—Support services.
388-310-1300 Community jobs.
388-310-1600 WorkFirst—Sanctions.
388-310-1800 WorkFirst—Post employment services.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-310-2100 Career services program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.08A.010. 10-14-084, § 388-310-2100, filed 7/2/10, effective 8/2/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 09-02-029, § 388-310-2100, filed 12/30/08, effective 2/1/09. Statutory Authority: RCW 74.04.050, 74.04.055. 08-16-102, § 388-310-2100, filed 8/5/08, effective 10/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, and 2007 c 522. 07-20-042, § 388-310-2100, filed 9/26/07, effective 10/27/07.] Repealed by 10-22-062, filed 10/29/10, effective 12/1/10. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW.

WAC 388-310-0100 WorkFirst—Purpose. (1) **What is the WorkFirst program?**

The WorkFirst program offers services and activities to help people in low-income families find jobs, keep their jobs, find better jobs and become self-sufficient. The program links families to a variety of state, federal and community resources to meet this goal. When you enter the WorkFirst program, you will be asked to work, look for work and/or prepare for work.

(2) **Who does the WorkFirst program serve?**

The WorkFirst program serves two groups:

(a) Parents and children age sixteen or older who receive cash assistance under the temporary assistance for needy families (TANF), general assistance for pregnant women (GA-S) or state family assistance (SFA) programs; and

(b) Low income parents who support their family without applying for or relying on cash assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.-090. 10-22-061, § 388-310-0100, filed 10/29/10, effective 12/1/10. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-08-051, § 388-310-0100, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0200 WorkFirst—Activities. (1) **Who is required to participate in WorkFirst activities?**

(a) You are required to participate in the WorkFirst activities in your individual responsibility plan, and become what is called a "mandatory participant," if you:

(i) Are receiving TANF or SFA cash assistance because you are pregnant or the parent or adult in the home; and

(ii) Are not exempt. For exemptions see WAC 388-310-0300 and 388-310-0350.

(b) Participation is voluntary for all other WorkFirst participants (those who no longer receive or have never received TANF or SFA cash assistance).

(2) **What activities do I participate in when I enter the WorkFirst program?**

When you enter the WorkFirst program, you will participate in one or more of the following activities (which are described in more detail in other sections of this chapter):

(a) Paid employment (see WAC 388-310-0400 (2)(a) and 388-310-1500);

(b) Self employment (see WAC 388-310-1700);

(c) Job search (see WAC 388-310-0600);

(d) Community jobs (see WAC 388-310-1300)

(e) Work experience (see WAC 388-310-1100);

(f) On-the-job training (see WAC 388-310-1200);

(g) Vocational educational training (see WAC 388-310-1000);

(h) Basic education activities (see WAC 388-310-0900);

(i) Job skills training (see WAC 388-310-1050);

(j) Community service (see WAC 388-310-1400);

(k) Activities provided by tribal governments for tribal members and other American Indians (see WAC 388-310-1400(1) and 388-310-1900);

(l) Other activities identified by your case manager on your individual responsibility plan that will help you with situations such as drug and/or alcohol abuse, homelessness, or mental health issues; and/or

(m) Activities identified by your case manager on your individual responsibility plan to help you cope with family violence as defined in WAC 388-61-001; and/or

(n) Up to ten hours of financial literacy activities to help you become self-sufficient and financially stable.

(3) **If I am a mandatory participant, how much time must I spend doing WorkFirst activities?**

If you are a mandatory participant, you will be required to participate in the activities in your individual responsibility plan, and may be required to participate full time, working, looking for work or preparing for work. You might be required to participate in more than one part-time activity at the same time that add up to full time participation. You will have an individual responsibility plan (described in WAC 388-310-0500) that includes the specific activities and requirements of your participation.

(4) **What activities do I participate in after I get a job?**

You may be required to participate in other activities, such as job search or training once you are working twenty hours or more a week in a paid unsubsidized job, to bring your participation up to full time.

You may also engage in activities if you are working full time and want to get a better job.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-22-062, § 388-310-0200, filed 10/29/10, effective 12/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.08A.340. 09-15-084, § 388-310-0200, filed 7/14/09, effective 8/14/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.340, and 2006 c 107. 06-24-023, § 388-310-0200, filed 11/29/06, effective 12/30/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0200, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-0200, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0200, filed 3/1/00, effective 3/1/00; 99-08-051, § 388-310-0200, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0350 WorkFirst—Other exemptions from mandatory participation. (1) **When am I exempt from mandatory participation?**

You are exempt from mandatory participation if you are:

(a) A caretaker relative as defined by WAC 388-484-0010, included in the assistance unit and:

(i) You are fifty-five years of age or older and caring for a child and you are not the child's parent; and

(ii) Your age is verified by any reliable documentation (such as a birth certificate or a driver's license).

(b) An adult with a severe and chronic disability as defined below and:

(i) You have been assessed by a DSHS SSI facilitator as likely to be approved for SSI or other benefits and are required to apply for SSI or another type of federal disability benefit (such as railroad retirement or Social Security disability) in your individual responsibility plan; and/or

(ii) Your disability is a severe and chronic mental, physical, emotional, or cognitive impairment that prevents you from participating in work activities for more than ten hours a week and is expected to last at least twelve months; and

(iii) Your disability and ability to participate is verified by documentation from the division of developmental disabilities (DDD), division of vocational rehabilitation (DVR), home and community services division (HCS), division of mental health (MHD), and/or regional support network (RSN), or evidence from another medical or mental health professional; and

(iv) Your SSI application status may be verified through the SSI facilitator and/or state data exchange.

(c) Required in the home to care for a child with special needs when:

(i) The child has a special medical, developmental, mental, or behavioral condition; and

(ii) The child is determined by a public health nurse, physician, mental health provider, school professional, other medical professional, HCS, MHD, and/or a RSN to require specialized care or treatment that prevents you from participating in work activities for more than ten hours per week.

(d) Required to be in the home to care for another adult with disabilities when:

(i) The adult with disabilities cannot be left alone for significant periods of time; and

(ii) No adult other than yourself is available and able to provide the care; and

(iii) The adult with the disability is related to you; and

(iv) You are unable to participate in work activities for more than ten hours per week because you are required to be in the home to provide care; and

(v) The disability and your need to care for your disabled adult relative is verified by documentation from DDD, DVR, HCS, MHD, and/or a RSN, or evidence from another medical or mental health professional.

(2) **Who reviews and approves an exemption from participation?**

(a) If it appears that you may qualify for an exemption or you ask for an exemption, your case manager or social worker will review the information and we may use the case staffing process to determine whether the exemption will be approved. Case staffing is a process to bring together a team of multidisciplinary experts including relevant professionals and the client to identify participant issues, review case history and information, and recommend solutions.

(b) If additional medical or other documentation is needed to determine if you are exempt, your IRP will allow between thirty days and up to ninety if approved to gather the necessary documentation.

(c) Information needed to verify your exemption should meet the standards for verification described in WAC 388-490-0005. If you need help gathering information to verify your exemption, you can ask us for help. If you have been identified as needing NSA services, under chapter 388-472 WAC, your accommodation plan should include information

on how we will assist you with getting the verification needed.

(d) After a case staffing, we will send you a notice that tells you whether your exemption was approved, how to request a fair hearing if you disagree with the decision, and any changes to your IRP that were made as a result of the case staffing.

(3) **Can I participate in WorkFirst while I am exempt?**

(a) You may choose to participate in WorkFirst while you are exempt.

(b) Your WorkFirst case manager may refer you to other service providers who may help you improve your skills and move into employment.

(c) If you decide later to stop participating, and you still qualify for an exemption, you will be put back into exempt status with no financial penalty.

(4) **Does an exemption from participation affect my sixty-month time limit for receiving TANF/SFA benefits?**

Even if exempt from participation, each month you receive a TANF/SFA grant counts toward your sixty-month limit as described in WAC 388-484-0005.

(5) **How long will my exemption last?**

Unless you are an older caretaker relative, your exemption will be reviewed at least every twelve months to make sure that you still meet the criteria for an exemption. Your exemption will continue as long as you continue to meet the criteria for an exemption.

(6) **What happens when I am no longer exempt?**

If you are no longer exempt, then:

(a) You will become a mandatory participant under WAC 388-310-0400; and

(b) If you have received sixty or more months of TANF/SFA, your case will be reviewed for an extension. (See WAC 388-484-0006 for a description of TANF/SFA time limit extensions.)

(7) For time-limited extensions, see WAC 388-484-0006.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-24-013, § 388-310-0350, filed 11/18/10, effective 12/19/10. Statutory Authority: RCW 74.04.050, 74.08.-090, and 74.08A.340. 09-16-079, § 388-310-0350, filed 7/31/09, effective 9/1/09; 03-24-057, § 388-310-0350, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-310-0350, filed 5/31/02, effective 6/1/02.]

WAC 388-310-0400 WorkFirst—Entering the WorkFirst program as a mandatory participant. (1) **What happens when I enter the WorkFirst program as a mandatory participant?**

If you are a mandatory participant, you must follow instructions as written in your individual responsibility plan (see WAC 388-310-0500), which is written after you have participated in a comprehensive evaluation of elements related to your employability. If you have been identified as someone who needs necessary supplemental accommodation (NSA) services (defined in chapter 388-472 WAC) your case manager will first develop an accommodation plan to help you access WorkFirst services. The case manager will use the accommodation plan to help develop your IRP with you. If you have been identified as a victim of family violence (defined in WAC 388-61-001), you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

If you are a mandatory participant, your case manager will refer you to WorkFirst activities unless any of the following applies to you:

(a) You work thirty-two or more hours a week (or, if you are a member of a two-parent family, you work thirty-five hours or more a week). **"Work"** means to engage in any legal, income generating activity which is taxable under the United States tax code or which would be taxable with or without a treaty between an Indian Nation and the United States;

(b) You participate the equivalent of twenty or more hours a week (or if you are a member of a two-parent family, you participate the equivalent of thirty or more hours a week) in job search, vocational education, issue resolution, or paid or unpaid work that meets the federal definition of core activities, which may include work of sixteen or more hours a week in the federal or state work study program, and you attend a Washington state community or technical college at least half time;

(c) You work twenty or more hours a week (or if you are a member of a two-parent family, you work thirty or more hours a week) in unsubsidized employment and attend a Washington state community or technical college at least half time;

(d) You are under the age of eighteen, have not completed high school, GED or its equivalent and are in school full time;

(e) You are eighteen or nineteen years of age and are attending high school or an equivalent full time;

(f) You are pregnant or have a child under the age of twelve months, and are participating in other pregnancy to employment activities. See WAC 388-310-1450;

(g) Your situation prevents you from looking for a job and you are conducting activities identified on your IRP to help you with your situation. (For example, you may be unable to look for a job while you have health problems or you are homeless); or

(h) Your situation prevents you from looking for work because you are a victim of family violence and you are conducting activities on your IRP to help you with your situation.

(2) **How will I know what my participation requirements are?**

(a) Your individual responsibility plan will describe what you need to do to be able to enter job search or other WorkFirst activities and then find a job (see WAC 388-310-0500 and 388-310-0700).

(b) If you enter the pregnancy to employment pathway (described in WAC 388-310-1450(3)), you must take part in an assessment.

(3) **What happens if I do not follow my WorkFirst requirements?**

If you do not participate in creating an individual responsibility plan, job search, or in the activities listed in your individual responsibility plan, and you do not have a good reason, the department will follow the sanction rules in WAC 388-310-1600.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-22-062, § 388-310-0400, filed 10/29/10, effective 12/1/10. Statutory Authority: 45 C.F.R. 260, 42 U.S.C.

601, chapters 74.08A and 74.12 RCW, RCW 74.04.050, 74.04.055, 74.08.-090, and 74.04.057. 09-14-019, § 388-310-0400, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 08-07-046, § 388-310-0400, filed 3/14/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-08-044, § 388-310-0400, filed 3/30/06, effective 6/1/06. Statutory Authority: RCW 74.08A.-010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0400, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0400, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0400, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0400, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0800 WorkFirst—Support services. (1) **Who can get support services?**

People who can get support services include:

(a) WorkFirst participants who receive a TANF cash grant;

(b) Sanctioned WorkFirst participants during the required participation before the sanction is lifted or applicants who were terminated while in noncompliance sanction who are doing activities required to reopen cash assistance (WAC 388-310-1600);

(c) Unmarried or pregnant minors who are income eligible to receive TANF and are:

(i) Living in a department approved living arrangement (WAC 388-486-0005) and are meeting the school requirements (WAC 388-486-0010); or

(ii) Are actively working with a social worker and need support services to remove the barriers that are preventing them from living in a department approved living arrangement and/or meeting the school requirements.

(d) American Indians who receive a TANF cash grant and have identified specific needs due to location or employment.

(2) **Why do I receive support services?**

Although not an entitlement, you may receive support services for the following reasons:

(a) To help you participate in work and WorkFirst activities that lead to independence.

(b) To help you to participate in job search, accept a job, keep working, advance in your job, and/or increase your wages.

(c) You can also get help in paying your child care expenses through the working connections child care assistance program. (Chapter 170-290 WAC describes the rules for this child care assistance program.)

(3) **What type of support services may I receive and what limits apply?**

There is a limit of three thousand dollars per person per program year (July 1st to June 30th) for WorkFirst support services you may receive. Most types of support services have dollar limits.

The chart below shows the types of support services that are available for the different activities (as indicated by an "x") and the limits that apply.

Definitions:

• Work-related activities include looking for work or participating in workplace activities, such as community jobs or a work experience position.

•• Safety-related activities include meeting significant or emergency family safety needs, such as dealing with family violence. When approved, safety-related support services can exceed the dollar or category limits listed below.

••• Some support services are available if you need them for other required activities in your IRP.

Type of support service	Limit	• Work	•• Safety	••• Other
Reasonable accommodation for employment	$1,000 for each request	x		
Clothing/uniforms	$75 per adult per program year	x		
Diapers	$50 per child per month	x		
Haircut	$40 per each request	x		
Lunch	Same rate as established by OFM for state employees	x		
Personal hygiene	$50 per adult per program year	x		
Professional, trade, association, union and bonds	$300 for each fee	x		
Relocation related to employment (can include rent, housing, and deposits)	$1,000 per program year	x		
Short-term lodging and meals in connection with job interviews/tests	Same rate as established by OFM for state employees	x		
Tools/equipment	$500 per program year	x		
Car repair needed to restore car to operable condition	$250 per program year	x	x	
License/fees	$130 per program year	x	x	
Mileage, transportation, and/or public transportation	Same rate as established by OFM for state employees	x	x	
Transportation allotment	Up to: $25 for immediate need, or $40 twice a month if you live within 40 miles of your local WorkFirst office, or $60 twice a month if you live more than 40 miles from your local WorkFirst office.	x	x	
Counseling	No limit	x	x	x

Type of support service	Limit	• Work	•• Safety	••• Other
Educational expenses	$300 for each request if it is an approved activity in your IRP and you do not qualify for sufficient student financial aid to meet the cost	x		x
Medical exams (not covered by medicaid)	$150 per exam	x	x	x
Public transportation	$150 per month	x	x	x
Testing-diagnostic	$200 each	x	x	x

(4) **What are the other requirements to receive support services?**

Other restrictions on receiving support services are determined by the department or its agents. They will consider whether:

(a) It is within available funds; and

(b) It does not assist, promote, or deter religious activity; and

(c) There is no other way to meet the cost.

(5) **What happens to my support services if I do not participate as required?**

The department will give you ten days notice, following the rules in WAC 388-310-1600, then discontinue your support services until you participate as required.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 10-22-061, § 388-310-0800, filed 10/29/10, effective 12/1/10; 09-06-053, § 388-310-0800, filed 2/26/09, effective 4/1/09. Statutory Authority: RCW 74.04.050 and 74.04.055. 08-18-045, § 388-310-0800, filed 8/29/08, effective 10/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW. 06-10-035, § 388-310-0800, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340. 05-02-014, § 388-310-0800, filed 12/27/04, effective 1/27/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340, and 2003 c 10 § 207. 03-21-154, § 388-310-0800, filed 10/22/03, effective 10/27/03. Statutory Authority: RCW 74.08.090, 74.04.050, 78.08A.340, and [WSR] 99-14-043. 02-11-130, § 388-310-0800, filed 5/21/02, effective 7/1/02; 01-17-053, § 388-310-0800, filed 8/13/01, effective 9/1/01. Statutory Authority: RCW 74.08.090, 74.04.050, and 78.08A.340. 00-13-106, § 388-310-0800, filed 6/21/00, effective 7/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-14-043, § 388-310-0800, filed 6/30/99, effective 7/31/99; 97-20-129, § 388-310-0800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1300 Community jobs. (1) **What is the community jobs program?**

Community jobs is a paid work experience that assists you to gain work skills and experience. You are placed in a community job (up to twenty hours per week) where your wages are paid by the community jobs program. If you participate in the program, you are eligible for support services that assist you in moving into a job where your employer pays all your wages.

(2) **What is career jump?**

Career jump offers job-ready community jobs participants an opportunity to gain paid work experience that leads to a permanent job. This program is a subset of community jobs and will be referred to as such. Career jump places you in a part time (up to twenty hours per week), community job where your earnings are paid by the community jobs program, for up to five months, at which time you will transition to the employer's payroll. You will be provided with support services to assist you in retaining your job through the ninth month of the program. At or before the fifth month, the employment opportunity will be above minimum wage, thirty-two or more hours per week and include wage progression and benefits comparable to other employees.

(3) **Who administers the community jobs program?**

The state department of community, trade, and economic development (DCTED) administers the community jobs program. DCTED contract with local agencies throughout the state, known as community jobs contractors who develop and manage the community jobs positions, pay the wages, provide support services and act as the "employer of record" while you are enrolled in a community job.

(4) **What types of work sites are used to provide community jobs?**

The following work sites may be used to provide community jobs:

(a) Federal, state or local governmental agencies and tribal governments;

(b) Private and tribal nonprofit businesses, organizations and educational institutions;

(c) Private for profit businesses for career jump placements.

(5) **What are the requirements for the work sites?**

Work sites for community jobs and career jump:

(a) Must assist in strengthening work ethics, improve workplace skills and help you gain skills to move into a job where the employer pays all your wages. If they do not meet this requirement, they will not be considered for additional community jobs/career jump placements.

(b) We will follow the employment rules described in WAC 388-310-1500. In any situation where training is inconsistent with the terms of a collective bargaining agreement, your community jobs contractor will obtain written approval from the labor organization concerned. Career jump employers will remain neutral with regard to neutralization in the worksite.

(c) You will not be required to do work related to religious, electoral or partisan political activities.

(6) **What are the benefits of community jobs?**

You benefit from community jobs by:

(a) Learning work skills;

(b) Getting work experience;

(c) Working twenty hours per week, while being paid federal or state minimum wage, whichever is higher; and

(d) Earning paid personal leave as determined by DCTED.

(7) **How do I get into community jobs?**

You will be placed into community jobs after you and your DSHS case manager decide:

(a) You would benefit from community jobs after you have participated in job search without finding a job; and/or

(b) You need a supportive work environment to help you become more employable.

(8) **What happens after I am placed in the community jobs program?**

When you are placed in the community jobs program by DSHS:

(a) You will be assigned to a community job by the community jobs contractor for no more than nine months. You will work twenty hours a week and participate in any other unpaid activities for twelve to twenty additional hours per week as required in your individual responsibility plan;

(b) Your placement in community jobs will be reviewed by your DSHS case manager every three months during your nine-month placement for the following:

(i) To ensure you are TANF/SFA eligible; and

(ii) To verify any earned or unearned income received by you or another member of your assistance unit (that is, you and other people in your household who are included on your cash grant).

(c) Your community jobs contractor will review your case each month to ensure you are following your IRP and IDP, participating full time, and becoming more employable because of your community job;

(d) If you request a different community jobs placement, we do not consider your request a refusal to participate without good cause under WAC 388-310-1600. You may be asked to explain why you want a different placement;

(e) Grievance policies are in place for your protection. You will be required to sign an acknowledgment that you received a copy of this policy at the time of placement with the employer.

(9) **How does community jobs affect my TANF benefits?**

The amount of your TANF/SFA monthly grant will be determined by following the rules in WAC 388-450-0050 and 388-450-0215 (1), (3), (4), (5) and (6). WAC 388-450-0215(2), does not apply to your community jobs wages.

(10) **What can I expect from my career jump placement?**

(a) You cannot represent more than ten percent of the total labor force for an employer that has ten or more employees.

(b) No more than one community jobs participant shall be allowed per private for profit worksite supervisor.

(c) You will participate in developing a career progression plan that will include health care benefits comparable to other employees.

(d) You may be eligible for unemployment benefits if you have participated in community jobs' career jump and have worked at least six hundred eighty hours in a base year. You will gain unemployment insurance credits for all hours worked under your career jump placement.

(e) Your employer and your community jobs contractor will be required to follow DCTED's contractual agreements for career jump.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-22-062, § 388-310-1300, filed 10/29/10, effective 12/1/10. Statutory Authority: RCW 74.08.090, 74.04.-050, 74.08A.330, and 74.08A.320. 02-20-073, § 388-310-1300, filed 9/30/02, effective 10/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-08-051, § 388-310-1300, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.08.090, 74.04.050 and 74.08A.320. 98-10-054, § 388-310-1300, filed 4/30/98, effective 5/31/98.]

WAC 388-310-1600 WorkFirst—Sanctions. Effective July 1, 2010.

(1) **What WorkFirst requirements do I have to meet?**

You must do the following when you are a mandatory WorkFirst participant:

(a) Give the department the information we need to develop your individual responsibility plan (IRP) (see WAC 388-310-0500);

(b) Show that you are participating fully to meet all of the requirements listed on your individual responsibility plan;

(c) Go to scheduled appointments listed in your individual responsibility plan;

(d) Follow the participation and attendance rules of the people who provide your assigned WorkFirst services or activities; and

(e) Accept available paid employment when it meets the criteria in WAC 388-310-1500.

(2) **What happens if I don't meet WorkFirst requirements?**

(a) If you do not meet WorkFirst requirements, we will send you a letter telling you what you did not do, and inviting you to a noncompliance sanction case staffing.

(i) A noncompliance case staffing is a meeting with you, your case manager, and other people who are working with your family, such as representatives from tribes, community or technical colleges, employment security, the children's administration, family violence advocacy providers or limited-English proficient (LEP) pathway providers to review your situation and compliance with your participation requirements.

(ii) You will be notified when your noncompliance sanction case staffing is scheduled so you can attend.

(iii) You may invite anyone you want to come with you to your case staffing.

(b) You will have ten days to contact us so we can talk with you about your situation. You can contact us in writing, by phone, by going to the noncompliance sanction case staffing appointment described in the letter, or by asking for an individual appointment.

(c) If you do not contact us within ten days, we will make sure you have been screened for family violence and other barriers to participation. We will use existing information to decide whether:

(i) You were unable to do what was required; or

(ii) You were able, but refused, to do what was required.

(d) If you had a good reason not to do a required activity we will work with you and may change the requirements in your individual responsibility plan if a different WorkFirst activity would help you move towards independence and employment sooner. If you have been unable to meet your WorkFirst requirements because of family violence, you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

(3) **What is considered a good reason for not doing what WorkFirst requires?**

You have a good reason if you were not able to do what WorkFirst requires (or get an excused absence, described in WAC 388-310-0500(5)) due to a significant problem or event outside your control. Some examples of good reasons include, but are not limited to:

(a) You had an emergent or severe physical, mental or emotional condition, confirmed by a licensed health care professional that interfered with your ability to participate;

(b) You were threatened with or subjected to family violence;

(c) You could not locate child care for your children under thirteen years that was:

(i) Affordable (did not cost you more than your copayment would under the working connections child care program in chapter 170-290 WAC);

(ii) Appropriate (licensed, certified or approved under federal, state or tribal law and regulations for the type of care you use and you were able to choose, within locally available options, who would provide it); and

(iii) Within a reasonable distance (within reach without traveling farther than is normally expected in your community).

(iv) You could not locate other care services for an incapacitated person who lives with you and your children.

(d) You had an immediate legal problem, such as an eviction notice; or

(e) You are a person who gets necessary supplemental accommodation (NSA) services under chapter 388-472 WAC and your limitation kept you from participating. If you have a good reason because you need NSA services, we will review your accommodation plan.

(4) **What happens in my noncompliance sanction case staffing?**

(a) At your noncompliance case staffing we will ensure you were offered the opportunity to participate and discuss with you:

(i) What happens if you are sanctioned and stay in sanction;

(ii) How you can participate and get out of sanction;

(iii) How you and your family benefit when you participate in WorkFirst activities;

(iv) That if you continue to refuse to participate, without good cause, your case may be closed after you have been in sanction status for four months in a row;

(v) How you plan to care for and support your children if your case is closed. We will also discuss the safety of your family, as needed, using the guidelines under RCW 26.44.030; and

(vi) How to reapply if your case is closed.

(b) If you do not come to your noncompliance sanction case staffing, we will make a decision based on the information we have.

(5) **What if we decide that you did not have a good reason for not meeting WorkFirst requirements?**

(a) Before you are placed in sanction, a supervisor will review your case to make sure:

(i) You knew what was required;

(ii) You were told how to end your sanction;

(iii) We tried to talk to you and encourage you to participate; and

(iv) You were given a chance to tell us if you were unable to do what we required.

(b) If we decide that you did not have a good reason for not meeting WorkFirst requirements, and a supervisor approves the sanction, we will send you a letter that tells you:

(i) What you failed to do;

(ii) That you are in sanction status;

(iii) Penalties that will be applied to your grant;

(iv) When the penalties will be applied;

(v) How to request a fair hearing if you disagree with this decision; and

(vi) How to end the penalties and get out of sanction status.

(c) We will also provide you with information about resources you may need if your case is closed. If you are sanctioned, then we will actively attempt to contact you another way so we can talk to you about the benefits of participation and how to end your sanction.

(6) **What is sanction status?**

When you are a mandatory WorkFirst participant, you must follow WorkFirst requirements to qualify for your full grant. If you or someone else on your grant doesn't do what is required and you can't prove that you had a good reason, you do not qualify for your full grant. This is called being in WorkFirst sanction status.

(7) **Are there penalties when you or someone in your household goes into sanction status?**

(a) When someone in your household is in sanction status, we impose penalties. The penalties last until you or the household member meet WorkFirst requirements.

(b) Your grant is reduced by one person's share or forty percent, whichever is more.

(8) **How do I end the penalties and get out of sanction status?**

To stop the penalties and get out of sanction status:

(a) You must provide the information we requested to develop your individual responsibility plan; and/or

(b) Start and continue to do your required WorkFirst activities for four weeks in a row (that is, twenty-eight calendar days).

(c) When you leave sanction status, your grant will be restored to the level you are eligible for beginning the first of the month following your four weeks of participation. For example, if you finished your four weeks of participation on June 15, your grant would be restored on July 1.

(9) **What if I reapply for TANF or SFA and I was in sanction status when my case closed?**

If your case closes while you are in sanction status and is reopened, you will start out where you left off in sanction.

That is, if you were in month two of sanction when your case closed, you will be in month three of sanction when you are approved for TANF or SFA.

(10) **What happens if I stay in sanction status?**

(a) We will send information to a supervisor or designee with a recommendation to close your case.

(b) A supervisor or designee will make the final decision.

(c) If the supervisor or designee approves case closure, your case will be closed after you have been in sanction for four months in a row.

(11) **What happens when a supervisor or designee approves closure of my case?**

When a supervisor or designee approves closure of your case, we will send you a letter to tell you:

(a) What you failed to do;

(b) When your case will be closed;

(c) How to request a fair hearing if you disagree with this decision;

(d) How to end your penalties and keep your case open (if you are able to participate for four weeks in a row before we close your case); and

(e) How your participation before your case is closed can be used to meet the participation requirement in subsection (12).

(12) **What if I reapply for TANF or SFA after a supervisor or designee approved case closure and my case was closed?**

If a supervisor or designee approves case closure and we close your case, you must participate for four weeks in a row before you can receive cash. Once you have met your four week participation requirement, your cash benefits will start, going back to the date we had all the other information we needed to make an eligibility decision.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-24-069, § 388-310-1600, filed 11/30/10, effective 12/31/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 34.05.310, and chapters 74.08A and 74.12 RCW. 10-12-044, § 388-310-1600, filed 5/26/10, effective 7/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 34.05.310 (4)(c). 08-15-136, § 388-310-1600, filed 7/22/08, effective 8/22/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090. 07-09-081, § 388-310-1600, filed 4/17/07, effective 6/1/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW. 06-10-035, § 388-310-1600, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.340. 04-07-025, § 388-310-1600, filed 3/8/04, effective 5/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-1600, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1600, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1600, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1800 WorkFirst—Post employment services. (1) **What is the purpose of post employment services?**

Post employment services help TANF or SFA parents who are working twenty hours or more a week keep and cope with their current jobs, look for better jobs, gain work skills for a career and become self sufficient.

(2) **How do I obtain post employment services?**

(a) You can obtain post employment services by:

(i) Asking for a referral from the local community service office;

(ii) Contacting community or technical colleges; or

(iii) Contacting the employment security department.

(3) **Who provides post employment services and what kind of services do they provide?**

(a) The employment security department can help you increase your wages, increase your job skills or find a better job by providing you with:

(i) Employment and career counseling;

(ii) Labor market information;

(iii) Job leads for a better job (sometimes called job development);

(iv) On the job training;

(v) Help with finding a job that matches your interests, abilities and skills (sometimes called job matching); and

(vi) Help with finding a new job after job loss (sometimes called reemployment).

(b) Any Washington state technical and community college can approve a skill-training program for you that will help you advance up the career ladder. Their staff will talk to you, help you decide what training would work best for you and then help you get enrolled in these programs. The college may approve the following types of training for you at any certified institution:

(i) High school/GED,

(ii) Vocational education training,

(iii) Job skills training,

(iv) Adult basic education,

(v) English as a second language training, or

(vi) Preemployment training.

(4) **What other services are available while you receive post employment services?**

While you receive post employment services, you may qualify for:

(a) Working connections childcare if you meet the criteria for this program (described in chapter 170-290 WAC).

(b) Other support services, such as help in paying for transportation or work expenses if you meet the criteria for this program (WAC 388-310-0800).

(c) Other types of assistance for low-income families such as food stamps, medical assistance or help with getting child support that is due to you and your children.

(5) **Who is eligible for post employment services?**

If you are a current TANF or SFA recipient, you may qualify for post employment services if you are working twenty hours or more a week, unless you are in sanction status.

(6) **What if I lose my job while I am receiving post employment services?**

If you now receive TANF or SFA, help is available to you so that you can find another job and continue in your approved post employment services.

(a) The employment security department will provide you with reemployment services.

(b) At the same time, your case manager can approve support services and childcare for you.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 10-22-061, § 388-310-1800, filed 10/29/10, effective 12/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 34.05.310 (4)(c). 08-15-136, § 388-310-1800, filed 7/22/08, effective 8/22/08. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340, and 2003 c 10 § 207. 03-21-154, § 388-310-1800, filed 10/22/03, effective 10/27/03. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-1800, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-1800, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1800, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1800, filed 10/1/97, effective 11/1/97.]

Chapter 388-400 WAC
PROGRAM SUMMARY

WAC

388-400-0025 Who is eligible for disability lifeline benefits?
388-400-0040 Am I eligible for benefits through the Washington Basic Food program?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-400-0045 If I am not eligible for federal benefits through Washington Basic Food program because of my alien status, can I receive state-funded Basic Food? [Statutory

Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and Food and Nutrition Act of 2008, Title 7 Part 273 of the C.F.R. 09-07-054, § 388-400-0045, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-028, § 388-400-0045, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0045, filed 7/31/98, effective 9/1/98.] Repealed by 11-02-035, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090, and 74.08A.120.

WAC 388-400-0025 Who is eligible for disability lifeline benefits? (1) Effective March 29, 2010, the "general assistance" program was replaced by "disability lifeline." Any reference in Washington Administrative Code (WAC) to general assistance also applies to disability lifeline.

(2) You are eligible for disability lifeline (DL) benefits if you:

(a) Are incapacitated as required under WAC 388-448-0001 through 388-448-0120;

(b) Are at least eighteen years old or, if under eighteen, a member of a married couple;

(c) Are in financial need according to DL income and resource rules in chapters 388-450, 388-470 and 388-488 WAC. We determine who is in your assistance unit according to WAC 388-408-0010;

(d) Meet the disability lifeline citizenship/alien status requirements under WAC 388-424-0015(2);

(e) Provide a Social Security number as required under WAC 388-476-0005;

(f) Reside in the state of Washington as required under WAC 388-468-0005;

(g) Undergo referrals for assessment, treatment, or to other agencies as provided under WAC 388-448-0130 through 388-448-0150;

(h) Sign an interim assistance reimbursement authorization to agree to repay the monetary value of general assistance or disability lifeline benefits subsequently duplicated by Supplemental Security Income benefits as described under WAC 388-448-0200, 388-448-0210 and 388-474-0020;

(i) Report changes of circumstances as required under WAC 388-418-0005; and

(j) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(3) You aren't eligible for disability lifeline benefits if you:

(a) Have received general assistance or disability lifeline benefits for more than the maximum number of months as defined in WAC 388-448-0250.

(b) Are eligible for temporary assistance for needy families (TANF) benefits.

(c) Are eligible for state family assistance (SFA) benefits.

(d) Refuse or fail to meet a TANF or SFA eligibility rule.

(e) Refuse or fail to participate in drug or alcohol treatment as required in WAC 388-448-0220.

(f) Are eligible for Supplemental Security Income (SSI) benefits.

(g) Are an ineligible spouse of an SSI recipient.

(h) Failed to follow a Social Security Administration (SSA) program rule or application requirement and SSA denied or terminated your benefits.

(4) If you reside in a public institution and meet all other requirements, your eligibility for DL depends on the type of institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

(a) You may be eligible for disability lifeline if you are:

(i) A patient in a public medical institution; or

(ii) A patient in a public mental institution and:

(A) Sixty-five years of age or older; or

(B) Twenty years of age or younger.

(b) You aren't eligible for DL when you are in the custody of or confined in a public institution such as a state penitentiary or county jail including placement:

(i) In a work release program; or

(ii) Outside of the institution including home detention.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096, § 388-400-0025, filed 7/30/10, effective 9/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-13-043, § 388-400-0025, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 2004 c 54. 04-23-027, § 388-400-0025, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-400-0025, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.057, 74.08.090. 00-15-017, § 388-400-0025, filed 7/10/00, effective 9/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0040 Am I eligible for benefits through the Washington Basic Food program? The Washington Basic Food program (Basic Food) is a nutrition program to help low-income individuals and families buy food. This rule is a summary of the rules for Basic Food.

(1) When you apply for Basic Food, we decide who is in your assistance unit (AU) based on the requirements under WAC 388-408-0034 and 388-408-0035.

(2) To be eligible for Basic Food benefits, your AU must meet the eligibility requirements for the federal supplemental nutrition assistance program (SNAP) including:

(a) The most current version of the Food and Nutrition Act of 2008;

(b) Federal regulations adopted by the U.S. Department of Agriculture, Food and Nutrition Services (FNS) related to SNAP; and

(c) Standards FNS publishes each year for income limits, resource limits, income deductions, and benefit amounts for SNAP.

(3) To be eligible for Basic Food benefits, each AU member must:

(a) Meet the citizenship or alien status requirements for Basic Food benefits as described under WAC 388-424-0020.

(b) Be a resident of the state of Washington as required under WAC 388-468-0005;

(c) Give us their Social Security number as required under WAC 388-476-0005;

(d) Give us proof of identity as required under WAC 388-490-0005;

(e) Participate in the Basic Food employment and training program (BFE&T) if required under chapter 388-444 WAC; and

(f) Meet the eligibility criteria for strikers as described under WAC 388-480-0001.

(4) To be eligible for Basic Food, your AU must:

(a) Have total monthly income before taxes and deductions at or under the gross monthly income standard under WAC 388-478-0060. We don't use income that isn't counted under WAC 388-450-0015 as part of your AU's gross monthly income;

(b) Have net income at or under the net monthly income standard under WAC 388-478-0060. We subtract deductions allowed under WAC 388-450-0185 to determine your AU's net monthly income.

(c) Have resources we must count under WAC 388-470-0055 that are at or below your AU's resource limit under WAC 388-470-0005;

(d) Report changes of circumstances as required under WAC 388-418-0005; and

(e) Complete a mid-certification review and provide proof of any changes if required under WAC 388-418-0011.

(5) If your AU is categorically eligible for Basic Food under WAC 388-414-0001, your AU can have income over the gross or net income standard, and have resources over the resource limit and still be eligible for benefits.

(6) If your AU has income at or under the gross income standard or is categorically eligible for Basic Food, we determine if you are eligible for Basic Food and calculate your monthly benefits as described under WAC 388-450-0162.

(7) If an eligible person in your AU is elderly or disabled, some rules may help your AU to be eligible for Basic Food or to receive more Basic Food benefits. These include:

(a) Resources limits and excluding certain resources under chapter 388-470 WAC;

(b) An excess shelter deduction over the limit set for AUs without an elderly or disabled individual under WAC 388-450-0190;

(c) A deduction for a portion of the out-of-pocket medical expenses for the elderly or disabled individual as described under WAC 388-450-0200; and

(d) Being exempt from the **gross monthly income** standard under WAC 388-478-0060.

(8) For Basic Food, **elderly** means a person who is age sixty or older;

(9) For Basic Food, **disabled** means a person who:

(a) Receives SSI;

(b) Receives disability payments or blindness payments under Title I, II, XIV, or XVI of the Social Security Act;

(c) Receives disability retirement benefits from a state, local or federal government agency because of a disability considered permanent under section 221(i) of the Social Security Act;

(d) Receives disability benefits from the Railroad Retirement Act under sections 2 (a)(1)(iv) and (v) and:

(i) Meets Title XIX disability requirements; or

(ii) Is eligible for medicare.

(e) Receives disability-related medical assistance under Title XIX of the Social Security Act;

(f) Is a veteran and receives disability payments based on one hundred percent disability;

(g) Is a spouse of a veteran and:

(i) Either needs an attendant or is permanently housebound; or

(ii) Has a disability under section 221(i) of the Social Security Act and is eligible for death or pension payments under Title 38 of the USC.

(10) If a person in your household attends an institution of higher education and does not meet the requirements to be an eligible student under WAC 388-482-0005, we do not count this person as a member of your AU under WAC 388-408-0035.

(11) If your AU currently receives food benefits under WASHCAP or lives on or near an Indian reservation and receives benefits from a tribal food distribution program approved by FNS, your AU is not eligible for food assistance benefits through the Washington Basic Food program.

(12) If a person in your AU is ineligible for any of the following reasons, we count the ineligible person's income as described under WAC 388-450-0140:

(a) Able-bodied adults without dependents who are no longer eligible under WAC 388-444-0030;

(b) Persons fleeing a felony prosecution, conviction, or confinement under WAC 388-442-0010;

(c) Persons who do not attest to citizenship or alien status as defined in WAC 388-424-0001;

(d) Persons who are ineligible aliens under WAC 388-424-0020;

(e) Persons disqualified for an intentional program violation under WAC 388-446-0015;

(f) Persons who do not provide a Social Security number when required under WAC 388-476-0005; or

(g) Persons who failed to meet work requirements under chapter 388-444 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090, and 74.08A.120. 11-02-035, § 388-400-0040, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and Food and Nutrition Act of 2008, Title 7 Part 273 of the C.F.R. 09-07-054, § 388-400-0040, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-13-043, § 388-400-0040, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057, 74.04.510, and 2004 c 54. 04-21-025, § 388-400-0040, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-400-0040, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-14-040, § 388-400-0040, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-028, § 388-400-0040, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0040, filed 7/31/98, effective 9/1/98.]

Chapter 388-406 WAC
APPLICATIONS

WAC

388-406-0040 What happens if the processing of my application is delayed?
388-406-0055 When do my benefits start?

WAC 388-406-0040 What happens if the processing of my application is delayed? (1) We process your application for benefits as soon as possible. We do not intentionally delay processing your application for benefits for any reason. If we have enough information to decide eligibility for:

(a) Basic Food, we promptly process your request for benefits even if we need more information to determine eligibility for cash or medical;

(b) Medical assistance, we promptly process your request for medical even if we need more information to determine eligibility for cash or Basic Food.

(2) If you have completed your required interview under WAC 388-452-0005 and we have enough information to determine eligibility, then we promptly process your application even if it is after thirty days from the date of your application.

(3) If additional information is needed to determine eligibility, we give you:

(a) A written request for the additional information; and

(b) An additional thirty days to provide the information.

(4) If you fail to keep or reschedule your interview in the first thirty calendar days after filing your application, your application will be denied on the thirtieth day, or the first business day after the thirtieth day. If you are still interested in Basic Food benefits, you will need to reapply. Benefits will be based on your second application date.

(5) If we have not processed your application for Basic Food by the sixtieth day and:

(a) You are responsible for the delay, we deny your request for benefits.

(b) If we are responsible for the delay, we:

(i) Promptly process your request if we have the information needed to determine eligibility; or

(ii) Deny your request if we don't have enough information to determine eligibility. If we deny your request we notify you of your right to file a new application and that you may be entitled to benefits lost.

(6) If you reapply for Basic Food by the sixtieth day of your first application, met your interview requirements under WAC 388-452-0005, and are eligible, we start your benefits from:

(a) The date of your first application, if we caused the delay in the first thirty days; or

(b) The date we have enough information to make an eligibility decision, if you caused the delay in the first thirty days.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 11-02-036, § 388-406-0040, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 07-13-019, § 388-406-0040, filed 6/11/07, effective 7/12/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057, 74.04.510. 03-22-039, § 388-406-0040, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0040, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0040, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0055 When do my benefits start? The date we approve your application affects the amount of benefits you get. If you are eligible for:

(1) Cash assistance, your benefits start:

(a) The date we have enough information to make an eligibility decision; or

(b) No later than the thirtieth day for TANF, SFA, or RCA; or

(c) No later than the forty-fifth day for general assistance (GA) unless you are confined in a Washington state public institution as defined in WAC 388-406-0005 (6)(a) on the forty-fifth day, in which case your benefits will start on the date you are released from confinement.

(2) Basic Food, your benefits start from the date you applied unless:

(a) You are recertified for Basic Food. If you are recertified for Basic Food, we determine the date your benefits start under WAC 388-434-0010;

(b) You applied for Basic Food while living in an institution. If you apply for Basic Food while living in an institution, the date you are released from the institution determines your start date as follows. If you are expected to leave the institution:

(i) Within thirty days of the date we receive your application, your benefits start on the date you leave the institution; or

(ii) More than thirty days from the date we receive your application, we deny your application for Basic Food. You may apply for Basic Food again when your date of release from the institution is closer.

(c) We were unable to process your application within thirty days because of a delay on your part. If you caused the delay, but submit required verification by the end of the second thirty-day period, we approve your benefits starting the date you provide the required verification. We start your benefits from this date even if we denied your application for Basic Food.

(d) We initially denied your application for Basic Food and your assistance unit (AU) becomes categorically eligible (CE) within sixty days from the date you applied. If your AU becoming CE under WAC 388-414-0001 makes you eligible for Basic Food, the date we approve Basic Food is the date your AU became CE.

(e) You are approved for transitional food assistance under chapter 388-489 WAC. We determine the date transitional benefits start as described under WAC 388-489-0015.

(f) You receive transitional food assistance with people you used to live with, and are now approved to receive Basic Food in a different assistance unit:

(i) We must give the other assistance unit ten days notice as described under WAC 388-458-0025 before we remove you from the transitional food assistance benefits.

(ii) Your Basic Food benefits start the first of the month after we remove you from the transitional benefits. For example, if we remove you from transitional benefits on November 30th, you are eligible for Basic Food on December 1st.

(3) Medical assistance, the date your benefits start is stated in chapter 388-416 WAC.

(4) For long-term care, the date your services start is stated in WAC 388-106-0045.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010 and 7 C.F.R. 273.2(h). 10-11-033, § 388-406-0055, filed 5/11/10, effective 7/1/10. Statutory Authority: RCW 74.08.060, 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 2009 c 198. 09-20-031, § 388-406-0055, filed 9/29/09, effective 11/1/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-406-0055, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0055, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0055, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW

74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0055, filed 7/31/98, effective 9/1/98.]

Chapter 388-408 WAC
ASSISTANCE UNITS

WAC

388-408-0020 When am I not allowed to be in a TANF or SFA assistance unit?
388-408-0035 Who is in my assistance unit for Basic Food?

WAC 388-408-0020 When am I not allowed to be in a TANF or SFA assistance unit? Some people cannot be in an AU for TANF or SFA. This section describes who cannot be in your TANF or SFA AU and how this will affect your benefits.

(1) We do not include the following people in your TANF or SFA AU:

(a) A minor parent or child who has been placed in Title IV-E, state, or locally-funded foster care unless the placement is a temporary absence under WAC 388-454-0015;

(b) An adult parent in a two-parent household when:

(i) The other parent is unmarried and under the age of eighteen; and

(ii) We decide that your living arrangement is not appropriate under WAC 388-486-0005.

(c) A court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis* (in the place of a parent) if they are not a relative of one of the children in the AU as defined under WAC 388-454-0010; or

(d) Someone who gets SSI benefits.

(2) If someone that lives with you cannot be in the AU:

(a) We do not count them as a member of the AU when we determine the AU's payment standard; and

(b) We do not count their income unless they are financially responsible for a member of the AU under WAC 388-450-0095 through 388-450-0130.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 10-12-095, § 388-408-0020, filed 6/1/10, effective 7/2/10. Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0020, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.-510. 00-05-007, § 388-408-0020, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0035 Who is in my assistance unit for Basic Food? (1) For Basic Food, a person must be in your assistance unit (AU) if they live in the same home as you and:

(a) Regularly buy food or prepare meals with you; or

(b) You provide meals for them and they pay less than a reasonable amount for meals.

(2) If the following people live with you, they must be in your AU even if you do not usually buy or prepare food together:

(a) Your spouse;

(b) Your parents if you are under age twenty-two (even if you are married);

(c) Your children under age twenty-two;

(d) The parent of a child who must be in your AU;

(e) A child under age eighteen who doesn't live with their parent unless the child:

(i) Is emancipated;

(ii) Gets a TANF grant in their own name; or

(iii) Is not financially dependent on an adult in the AU because they get and have control of income of at least the TANF payment standard under WAC 388-478-0020(2) before taxes or other withholdings.

(3) If any of the people in subsections (1) or (2) already receive transitional food assistance under chapter 388-489 WAC, you can only receive benefits if they choose to reapply for Basic Food as described in WAC 388-489-0022.

(4) If you live in an institution where you may be eligible for Basic Food under WAC 388-408-0040, we decide who is in your AU as follows:

(a) If the facility is acting as your authorized representative under WAC 388-460-0015, we include you and anyone who must be in your AU under subsection (2) of this rule; or

(b) If you apply for benefits on your own, we include you, anyone who must be in your AU under subsection (2) of this rule, and other residents you choose to apply with.

(5) Anyone who must be in your AU under subsection (1) or (2) is an ineligible AU member if they:

(a) Are disqualified for an intentional program violation (IPV) under WAC 388-446-0015;

(b) Do not meet ABAWD work requirements under WAC 388-444-0030.

(c) Do not meet work requirements under WAC 388-444-0055;

(d) Do not provide a Social Security number under WAC 388-476-0005;

(e) Do not meet the citizenship or alien status requirements under chapter 388-424 WAC;

(f) Are fleeing a felony charge or violating a condition of parole or probation under WAC 388-442-0010.

(6) If your AU has an ineligible member:

(a) We count the ineligible member's income as part of your AU's income under WAC 388-450-0140;

(b) We count all the ineligible members resources to your AU; and

(c) We do not use the ineligible member to determine your AU's size for the maximum income amount or allotment under WAC 388-478-0060.

(7) If the following people live in the same home as you, you can choose if we include them in your AU:

(a) A permanently disabled person who is age sixty or over and cannot make their own meals if the total income of everyone else in the home (not counting the elderly and disabled person's spouse) is not more than the one hundred sixty-five percent standard under WAC 388-478-0060;

(b) A boarder. If you do not include a boarder in your AU, the boarder cannot get Basic Food benefits in a separate AU;

(c) A person placed in your home for foster care. If you do not include this person in your AU, they cannot get Basic Food benefits in a separate AU;

(d) Roomers; or

(e) Live-in attendants even if they buy or prepare food with you.

(8) If someone in your AU moves out of your home for at least a full issuance month, they are not eligible for benefits as a part of your AU, unless you receive transitional food assistance.

(9) For transitional food assistance, your TFA AU includes the people who were in your Basic Food AU for the last month you received:

(a) Temporary assistance for needy families;

(b) State family assistance; or

(c) Tribal TANF benefits.

(10) If someone received Basic Food or food stamps in another AU or another state, they cannot receive benefits in your AU for the same period of time with one exception. If you already received Basic Food, food stamp, or transitional food assistance benefits:

(a) In another state, you are not eligible for Basic Food for the period of time covered by the benefits you received from the other state; or

(b) In another AU, you are not eligible for Basic Food in a different AU for the same period of time;

(c) In another AU, but you left the AU to live in a shelter for battered women and children under WAC 388-408-0045, you may be eligible to receive benefits in a separate AU.

(11) The following people who live in your home are not members of your AU. If they are eligible for Basic Food, they may be a separate AU:

(a) Someone who usually buys and prepares food separately from your AU if they are not required to be in your AU; or

(b) Someone who lives in a separate residence.

(12) A student who is ineligible for Basic Food under WAC 388-482-0005 is not a member of your AU.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.010, and 74.08A.903. 10-13-047, § 388-408-0035, filed 6/9/10, effective 8/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-19-061, § 388-408-0035, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-14-040, § 388-408-0035, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-025, § 388-408-0035, filed 2/23/04, effective 4/1/04; 03-19-118, § 388-408-0035, filed 9/16/03, effective 11/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.-510. 01-21-060, § 388-408-0035, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0035, filed 7/31/98, effective 9/1/98.]

Chapter 388-416 WAC
CERTIFICATION PERIODS

WAC

388-416-0005 How long can I get Basic Food?

WAC 388-416-0005 How long can I get Basic Food? (1) The length of time the department determines your assistance unit (AU) is eligible to get Basic Food is called a certification period. The department may certify your AU for up to:

(a) **Six months** if your AU:

(i) Includes an able-bodied adult without dependents (ABAWD) who receives Basic Food in your AU and your AU does not live in an exempt area as described in WAC 388-444-0030;

(ii) Includes a person who receives ADATSA benefits as described in chapter 388-800 WAC;

(iii) Is considered homeless under WAC 388-408-0050; or

(iv) Includes a migrant or seasonal farmworker as described under WAC 388-406-0021.

(b) **Twelve months** if your AU does not meet any of the conditions for six months.

(2) If you receive transitional food assistance, we set your certification period as described under WAC 388-489-0015.

(3) If your AU is homeless **or** includes an ABAWD when you live in a nonexempt area, we may shorten your certification period.

(4) We terminate your Basic Food benefits when:

(a) We get proof of a change that makes your AU ineligible; or

(b) We get information that your AU is ineligible; and

(c) You do not provide needed information to verify your AU's circumstances.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 10-07-007, § 388-416-0005, filed 3/4/10, effective 4/4/10; 05-19-060, § 388-416-0005, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-08-124, § 388-416-0005, filed 4/5/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-19-134, § 388-416-0005, filed 9/21/04, effective 10/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-416-0005, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.08.-090 and 74.04.510. 01-11-107, § 388-416-0005, filed 5/21/01, effective 7/1/01; 99-16-024, § 388-416-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-418 WAC
CHANGE OF CIRCUMSTANCE

WAC

388-418-0005 How will I know what changes I must report?

WAC 388-418-0005 How will I know what changes I must report? You must report changes to the department based on the kinds of assistance you receive. We inform you of your reporting requirements on letters we send you about your benefits. Please follow the steps below to determine the types of changes you must report:

(1) If you receive assistance from any of the programs listed in subsection (a) through (e) of this section, you must report changes for people in your assistance unit under chapter 388-408 WAC, based on the **first** program you receive benefits from.

(a) If you receive **long term care** benefits such as a home and community based waiver (Basic, Basic Plus, CORE, Community Protection, COPES, New Freedom, Medically Needy), care in a medical institution (nursing home, hospice care center, state veterans home, ICF/MR, RHC) or hospice, you must tell us if you have a change of:

(i) Residence;

(ii) Marital status;

(iii) Living arrangement;

(iv) Income;

(v) Resources;

(vi) Medical expenses; and

(vii) If we allow you expenses for your spouse or dependents, you must report changes in their income or shelter cost.

(b) If you receive **medical benefits based on age, blindness, or disability (SSI-related medical), or ADATSA** benefits, you need to tell us if:

(i) You move;

(ii) A family member moves into or out of your home;

(iii) Your resources change; or

(iv) Your income changes. This includes the income of you, your spouse or your child living with you.

(c) If you receive **cash** benefits, other than WorkFirst career services benefits, you need to tell us if:

(i) You move;

(ii) Someone moves out of your home;

(iii) Your total gross monthly income goes over the:

(A) Payment standard under WAC 388-478-0030 if you receive general assistance; or

(B) Earned income limit under WAC 388-478-0035 and 388-450-0165 for all other programs;

(iv) You have liquid resources more than four thousand dollars; or

(v) You have a change in employment. Tell us if you:

(A) Get a job or change employers;

(B) Change from part-time to full-time or full-time to part-time;

(C) Have a change in your hourly wage rate or salary; or

(D) Stop working.

(d) If you are a relative or nonrelative caregiver and receive cash benefits on behalf of a child in your care but not for yourself or other adults in your household, you need to tell us if:

(i) You move;

(ii) The child you are caring for moves out of the home;

(iii) The child's parent moves into your home;

(iv) The child's earned or unearned income changes (see WAC 388-450-0070 for how we count the earned income of a child);

(v) The child has liquid resources more than four thousand dollars.

(e) If you receive **family medical** benefits, you need to tell us if:

(i) You move;

(ii) A family member moves out of your home; or

(iii) If your income goes up or down by one hundred dollars or more a month and you expect this income change will continue for at least two months.

If you do not receive assistance from any of the programs listed in subsection (a) through (e) of this section, but you do receive benefits from any of the programs listed in subsections (f) through (i) of this section, you must report changes for the people in your assistance unit under chapter 388-408 WAC, based on all the benefits you receive.

(f) If you receive **Basic Food** benefits, you need to tell us if:

(i) Your total gross monthly income is more than the gross monthly income limit under WAC 388-478-0060; or

(ii) Anyone who receives food benefits in your assistance unit must meet work requirements under WAC 388-444-0030 and their hours at work go below twenty hours per week.

(g) If you receive **children's medical** benefits, you need to tell us if:

(i) You move; or

(ii) A family member moves out of the house.

(h) If you receive **pregnancy medical** benefits, you need to tell us if:

(i) You move; or

(ii) You are no longer pregnant.

(i) If you receive **other medical** benefits, you need to tell us if:

(i) You move; or

(ii) A family member moves out of the home.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 10-07-007, § 388-418-0005, filed 3/4/10, effective 4/4/10. Statutory Authority: RCW 74.04.050, 74.04.055, and 2007 c 522. 07-20-042, § 388-418-0005, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-418-0005, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 44.04.280. 05-09-021, § 388-418-0005, filed 4/12/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-21-026, § 388-418-0005, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-026, § 388-418-0005, filed 2/23/04, effective 3/25/04; 03-21-028, § 388-418-0005, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-11-109, § 388-418-0005, filed 5/21/01, effective 7/1/01; 99-23-034, § 388-418-0005, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-424 WAC
CITIZENSHIP/ALIEN STATUS

WAC

388-424-0001 Citizenship and alien status—Definitions.
388-424-0006 Citizenship and alien status—Date of entry.
388-424-0009 Citizenship and alien status—Social Security number (SSN) requirements.
388-424-0010 Citizenship and alien status—Eligibility for TANF, medicaid, and CHIP.
388-424-0020 How does my alien status impact my eligibility for Washington Basic Food program benefits?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-424-0025 How does my alien status impact my eligibility for state-funded benefits under the Washington Basic Food program? [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0025, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-029, § 388-424-0025, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.08A.120. 00-13-036, § 388-424-0025, filed 6/13/00, effective 7/14/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.] Repealed by 11-02-035, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090, and 74.08A.120.

WAC 388-424-0001 Citizenship and alien status—Definitions. "American Indians" born outside the United States. American Indians born outside the U.S. are eligible for benefits without regard to immigration status or date of entry if:

(1) They were born in Canada and are of fifty percent American Indian blood (but need not belong to a federally recognized tribe); or

(2) They are members of a federally recognized Indian tribe or Alaskan native village or corporation.

"Hmong or Highland Lao." These are members of the Hmong or Highland Laotian tribe, which rendered military assistance to the U.S. during the Vietnam era (August 5, 1964 to May 7, 1975), and are "lawfully present" in the United States. This category also includes the spouse (including unremarried widow or widower) or unmarried dependent child of such tribe members.

"Nonimmigrants." These individuals are allowed to enter the U.S. for a specific purpose, usually for a limited time. Examples include:

(1) Tourists,

(2) Students,

(3) Business visitors.

"PRUCOL" (Permanently residing under color of law) aliens. These are individuals who:

(1) Are not "qualified aliens" as described below; and

(2) Intend to reside indefinitely in the U.S.; and

(3) United States Citizenship and Immigration Services or USCIS (formerly the Immigration and Naturalization Service or INS) knows are residing in the U.S. and is not taking steps to enforce their departure.

"Qualified aliens." Federal law defines the following groups as "qualified aliens." All those not listed below are considered "nonqualified":

(1) **Abused spouses or children,** parents of abused children, or children of abused spouses, who have either:

(a) A pending or approved I-130 petition or application to immigrate as an immediate relative of a U.S. citizen or as the spouse or unmarried son or daughter of a Lawful Permanent Resident (LPR) - see definition of LPR below; or

(b) A notice of "prima facie" approval of a pending self-petition under the Violence Against Women Act (VAWA); or

(c) Proof of a pending application for suspension of deportation or cancellation of removal under VAWA; and

(d) The alien no longer resides with the person who committed the abuse.

(e) Children of an abused spouse do not need their own separate pending or approved petition but are included in their parent's petition if it was filed before they turned age twenty-one. Children of abused persons who meet the conditions above retain their "qualified alien" status even after they turn age twenty-one.

(f) An abused person who has initiated a self-petition under VAWA but has not received notice of prima facie approval is not a "qualified alien" but is considered PRUCOL. An abused person who continues to reside with the person who committed the domestic violence is also PRUCOL. For a definition of PRUCOL, see above.

(2) **Amerasians** who were born to U.S. citizen armed services members in Southeast Asia during the Vietnam war.

(3) Individuals who have been granted **asylum** under Section 208 of the Immigration and Nationality Act (INA).

(4) Individuals who were admitted to the U.S. as **conditional entrants** under Section 203 (a)(7) of the INA prior to April 1, 1980.

(5) **Cuban/Haitian entrants.** These are nationals of Cuba or Haiti who were paroled into the U.S. or given other special status.

(6) Individuals who are **lawful permanent residents** (LPRs) under the INA.

(7) Persons who have been granted **parole** into the U.S. for at least a period of one year (or indefinitely) under Section 212 (d)(5) of the INA, including "public interest" parolees.

(8) Individuals who are admitted to the U.S. as **refugees** under Section 207 of the INA.

(9) **Special immigrants from Iraq and Afghanistan** are individuals granted special immigrant status under section 101 (a)(27) of the Immigration and Nationality Act (INA). Under federal law, special immigrants from Iraq and Afghanistan, their spouses and unmarried children under twenty-one are to be treated the same as refugees in their eligibility for public assistance.

(10) Persons granted **withholding of deportation or removal** under Sections 243(h) (dated 1995) or 241 (b)(3) (dated 2003) of the INA.

"Undocumented aliens." These are persons who either:

(1) Entered the U.S. without inspection at the border, or

(2) Were lawfully admitted but have lost their status.

"U.S. citizens."

(1) The following individuals are considered to be citizens of the U.S.:

(a) Persons born in the U.S. or its territories (Guam, Puerto Rico, and the U.S. Virgin Islands; also residents of the Northern Mariana Islands who elected to become U.S. citizens); or

(b) Legal immigrants who have naturalized after immigrating to the U.S.

(2) Persons born abroad to at least one U.S. citizen parent may be U.S. citizens under certain conditions.

(3) Individuals under the age of eighteen automatically become citizens when they meet the following three conditions on or after February 27, 2001:

(a) The child is a lawful permanent resident (LPR);

(b) At least one of the parents is a U.S. citizen by birth or naturalization; and

(c) The child resides in the U.S. in the legal and physical custody of the citizen parent.

(4) For those individuals who turned eighteen before February 27, 2001, the child would automatically be a citizen if still under eighteen when he or she began lawful permanent residence in the U.S. and both parents had naturalized. Such a child could have derived citizenship when only one parent had naturalized if the other parent were dead, a U.S. citizen by birth, or the parents were legally separated and the naturalizing parent had custody.

"U.S. nationals." A U.S. national is a person who owes permanent allegiance to the U.S. and may enter and work in the U.S. without restriction. The following are the only persons classified as U.S. nationals:

(1) Persons born in American Samoa or Swain's Island after December 24, 1952; and

(2) Residents of the Northern Mariana Islands who did not elect to become U.S. citizens.

"Victims of trafficking." According to federal law, victims of trafficking have been subject to one of the following:

(1) Sex trafficking, in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained eighteen years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through

the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

(3) Under federal law, persons who have been certified or approved as victims of trafficking by the federal Office of Refugee Resettlement (ORR) are to be treated the same as refugees in their eligibility for public assistance.

(4) Immediate family members of victims are also eligible for public assistance benefits as refugees. Immediate family members are the spouse or child of a victim of any age and the parent or minor sibling if the victim is under twenty-one years old.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.020, and Sec. 8120 of Pub. L 111-118 (DOD appropriations law); USDA Food and Nutrition Service federal guidance from January 29, 2010; U.S. DHHS Administration for Children and Families, Office of Family Assistance federal guidance letter No. TANF-ACF-PI-2010-05 issued on June 16, 2010. 10-15-045, § 388-424-0001, filed 7/13/10, effective 7/27/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-424-0001, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.-090. 04-15-004, § 388-424-0001, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0006 Citizenship and alien status—Date of entry. (1) A person who physically entered the U.S. prior to August 22, 1996 and who continuously resided in the U.S. prior to becoming a "qualified alien" (as defined in WAC 388-424-0001) is not subject to the five-year bar on TANF, nonemergency medicaid, and SCHIP.

(2) A person who entered the U.S. prior to August 22, 1996 but became "qualified" on or after August 22, 1996, or who physically entered the U.S. on or after August 22, 1996 and who requires five years of residency to be eligible for federal Basic Food, can only count years of residence during which they were a "qualified alien."

(3) A person who physically entered the U.S. on or after August 22, 1996 is subject to the five-year bar on TANF, nonemergency medicaid, and SCHIP unless exempt. The five-year bar starts on the date that "qualified" status is obtained.

(4) The following "qualified aliens," as defined in WAC 388-424-0001, are exempt from the five-year bar:

(a) Amerasian lawful permanent residents;

(b) Asylees;

(c) Cuban/Haitian entrants;

(d) Persons granted withholding of deportation or removal;

(e) Refugees;

(f) Special immigrants from Iraq and Afghanistan;

(g) Victims of trafficking who have been certified or had their eligibility approved by the office of refugee resettlement (ORR); and

(h) Lawful permanent residents, parolees, or battered aliens, as defined in WAC 388-424-0001, who are also an armed services member or veteran as described in WAC 388-424-0007.

(5) In addition to subsection (4) of this section, the following "qualified aliens" are also exempt from the five-year bar on nonemergency medicaid and SCHIP:

(a) Pregnant women;

(b) Children under nineteen years of age; and

(c) Children under twenty-one years of age who are residing in a medical institution as described in WAC 388-505-0230.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.020, and Sec. 8120 of Pub. L 111-118 (DOD appropriations law); USDA Food and Nutrition Service federal guidance from January 29, 2010; U.S. DHHS Administration for Children and Families, Office of Family Assistance federal guidance letter No. TANF-ACF-PI-2010-05 issued on June 16, 2010. 10-15-045, § 388-424-0006, filed 7/13/10, effective 7/27/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and P.L. No. 111-3 (H.R. 2, Title II, Sec. 214 - Children's Health Insurance Program Reauthorization Act of 2009); P.L. No. 111-08 Omnibus Appropriations Act of 2009, Office of Refugee Resettlement State Letter #09-17. 09-15-082, § 388-424-0006, filed 7/14/09, effective 8/14/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 07-07-023, § 388-424-0006, filed 3/9/07, effective 4/9/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.-090. 05-16-055, § 388-424-0006, filed 7/28/05, effective 8/28/05; 04-15-004, § 388-424-0006, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0009 Citizenship and alien status—Social Security number (SSN) requirements. (1) A "qualified alien," as defined in WAC 388-424-0001, who has applied for a Social Security number (SSN) as part of their application for benefits cannot have benefits delayed, denied, or terminated pending the issuance of the SSN by the Social Security Administration (SSA).

(2) The following immigrants are not required to apply for an SSN:

(a) An alien, regardless of immigration status, who is applying for a program listed in WAC 388-476-0005(7);

(b) A PRUCOL (permanently residing under color of law) alien who is not in one of the PRUCOL groups listed in WAC 388-424-0010(4); and

(c) Members of a household who are not applying for benefits for themselves.

(3) "Qualified aliens," as defined in WAC 388-424-0001, and PRUCOL aliens in any of the PRUCOL groups listed in WAC 388-424-0010(4), who are applying for federal benefits but who are not authorized to work in the U.S., must still apply for a nonwork SSN. The department must assist them in this application without delay.

(4) An immigrant who is otherwise eligible for benefits may choose not to provide the department with an SSN without jeopardizing the eligibility of others in the household. See WAC 388-450-0140 for how the income of such individuals is treated.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090, and CHIPRA of 2009, P.L. No. 111-3, Sec. 214; Sec. 8120, Title VIII, Division A of Department of Defense Appropriation Act of 2010, P.L. No. 111-118. 10-15-068, § 388-424-0009, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0009, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0010 Citizenship and alien status—Eligibility for TANF, medicaid, and CHIP. (1) To receive temporary assistance for needy families (TANF), medicaid, or children's health insurance program (CHIP) benefits, an individual must meet all other eligibility requirements and be one of the following as defined in WAC 388-424-0001:

(a) A United States (U.S.) citizen;

(b) A U.S. national;

(c) An American Indian born outside the U.S.;

(d) A "qualified alien";

(e) A victim of trafficking; or

(f) A Hmong or Highland Lao.

(2) A "qualified alien" who first physically entered the U.S. before August 22, 1996 as described in WAC 388-424-0006(1) may receive TANF, medicaid, and CHIP.

(3) A "qualified alien" who first physically entered the U.S. on or after August 22, 1996 cannot receive TANF, medicaid, or CHIP for five years after obtaining status as a qualified alien unless the criteria in WAC 388-424-0006 (4) or (5) are met.

(4) A child or pregnant woman in one of the following PRUCOL (permanently residing under color of law) groups may receive medicaid or CHIP:

(a) A citizen of a compact of free association state (Micronesia, Marshall Islands or Palau) who has been admitted to the U.S. as a nonimmigrant;

(b) An individual in temporary resident status as an amnesty beneficiary;

(c) An individual in temporary protected status;

(d) A family unity beneficiary;

(e) An individual currently under deferred enforced departure;

(f) An individual who is a spouse or child of a U.S. citizen with an approved Visa petition pending adjustment of status;

(g) A parent or child of an individual with special immigration status;

(h) A fiance of a U.S. citizen;

(i) A religious worker;

(j) An individual assisting the Department of Justice in a criminal investigation; or

(k) An individual with a petition of status pending of three years or longer.

(5) An alien who is ineligible for TANF, medicaid or CHIP because of the five-year bar or because of their immigration status may be eligible for:

(a) Emergency benefits as described in WAC 388-436-0015 (consolidated emergency assistance program) and WAC 388-438-0110 (alien medical program); or

(b) State-funded cash or chemical dependency benefits as described in WAC 388-424-0015 (state family assistance (SFA), general assistance (GA) and the alcohol and drug addiction treatment and support act (ADATSA)), and medical benefits as described in WAC 388-424-0016; or

(c) Pregnancy medical benefits as described in WAC 388-462-0015; or

(d) Apple health for kids as described in WAC 388-505-0210 (2) or (5).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090, and CHIPRA of 2009, P.L. No. 111-3, Sec. 214; Sec. 8120, Title VIII, Division A of Department of Defense Appropriation Act of 2010, P.L. No. 111-118. 10-15-068, § 388-424-0010, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and P.L. No. 111-3 (H.R. 2, Title II, Sec. 214 -Children's Health Insurance Program Reauthorization Act of 2009); P.L. No. 111-08 Omnibus Appropriations Act of 2009, Office of Refugee Resettlement State Letter #09-17. 09-15-082, § 388-424-0010, filed 7/14/09, effective 8/14/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-424-0010, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-424-0010, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0010, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-424-0010, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and Public Law 106-395. 02-03-008, § 388-424-0010, filed 1/4/02, effective 2/4/02. Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0010, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520 and 388-518-1805.]

WAC 388-424-0020 How does my alien status impact my eligibility for Washington Basic Food program benefits? (1) If you are a U.S. citizen or U.S. national as defined in WAC 388-424-0001 and meet all other eligibility requirements, you may receive Basic Food benefits.

(2) If you are not a U.S. citizen or U.S. national, you must fall within (a) or (b) of this subsection, and meet all other eligibility requirements, in order to receive Basic Food benefits:

(a) You are a member of one of the following groups of lawful immigrants as defined in WAC 388-424-0001:

(i) Amerasian;

(ii) Asylee;

(iii) Cuban or Haitian entrant;

(iv) Deportation or removal withheld;

(v) Refugee;

(vi) Special immigrant from Iraq or Afghanistan;

(vii) Victim of trafficking;

(viii) Noncitizen American Indian; or

(ix) Hmong or Highland Lao tribal member.

(b)(i) You are a member of one of the following groups of qualified aliens as defined in WAC 388-424-0001:

(A) Conditional entrant;

(B) Lawful permanent resident (LPR);

(C) Paroled for one year or more; or

(D) Abused spouse or child or parent or child of an abused spouse or child.

(ii) And, one of the following also applies to you:

(A) You have worked or can get credit for forty Social Security Administration (SSA) work quarters - as described in WAC 388-424-0008;

(B) You are an active duty personnel or honorably discharged veteran of the U.S. military or you are the spouse, unmarried surviving spouse, or unmarried dependent child of someone who meets this requirement, as described in WAC 388-424-0007;

(C) You receive cash or medical benefits based on Supplemental Security Income (SSI) criteria for blindness or disability;

(D) You have lived in the U.S. as a "qualified alien" as described in WAC 388-424-0001 for at least five years;

(E) You are under age eighteen; or

(F) You were lawfully residing in the U.S. on August 22, 1996 and were born on or before August 22, 1931.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090, and 74.08A.120. 11-02-035, § 388-424-0020, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.020, and Sec. 8120 of Pub. L 111-118 (DOD appropriations law); USDA Food and Nutrition Service federal guidance from January 29, 2010; U.S. DHHS Administration for Children and Families, Office of Family Assistance federal guidance letter No. TANF-ACF-PI-2010-05 issued on June 16, 2010. 10-15-045, § 388-424-0020, filed 7/13/10, effective 7/27/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.320, Pub. L. No. 110-181, National Defense

Authorization Act for Fiscal Year 2008, Pub. L. No. 111-08, the Omnibus Appropriations Act of 2009, Division F, Title VI, Section 602; Office of Refugee Resettlement State Letter 09-17 from April 9, 2009; and federal guidance issued on May 15, 2009, by the Food and Nutrition Service, United States Department of Agriculture. 09-21-046, § 388-424-0020, filed 10/14/09, effective 11/4/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-424-0020, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0020, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-029, § 388-424-0020, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and H.R. 2646 Farm Security and Rural Investment Act of 2002. 02-22-046, § 388-424-0020, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.510, S. 1150, the Agricultural Research, Extension, and Education Reform Act of 1998. 99-01-058, § 388-424-0020, filed 12/11/98, effective 1/11/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

Chapter 388-432 WAC
DIVERSION ASSISTANCE

WAC

388-432-0005 Can I get help from DSHS for a family emergency without receiving monthly cash assistance?

WAC 388-432-0005 Can I get help from DSHS for a family emergency without receiving monthly cash assistance? DSHS has a program called diversion cash assistance (DCA). If your family needs an emergency cash payment but does not need ongoing monthly cash assistance, you may be eligible for this program.

(1) To get DCA, you must:

(a) Meet all the eligibility rules for temporary assistance for needy families (TANF)/state family assistance (SFA) except:

(i) You do not have to participate in WorkFirst requirements as defined in chapter 388-310 WAC; and

(ii) You do not have to assign child support rights or cooperate with division of child support as defined in chapter 388-422 WAC.

(b) Have a current bona fide or approved need for living expenses;

(c) Provide proof that your need exists; and

(d) Have or expect to get enough income or resources to support yourselves for at least twelve months.

(2) You may get DCA to help pay for one or more of the following needs:

(a) Child care;

(b) Housing;

(c) Transportation;

(d) Expenses to get or keep a job;

(e) Food costs, but not if an adult member of your family has been disqualified for food stamps; or

(f) Medical costs, except when an adult member of your family is not eligible because of failure to provide third party liability (TPL) information as defined in WAC 388-505-0540.

(3) DCA payments are limited to:

(a) One thousand two hundred fifty dollars once in a twelve-month period which starts with the month the DCA benefits begin; and

(b) The cost of your need.

(4) We do not budget your income or make you use your resources to lower the amount of DCA payments you can receive.

(5) DCA payments can be paid:

(a) All at once; or

(b) As separate payments over a thirty-day period. The thirty-day period starts with the date of your first DCA payment.

(6) When it is possible, we pay your DCA benefit directly to the service provider.

(7) You are not eligible for DCA if:

(a) Any adult member of your assistance unit got DCA within the last twelve months;

(b) Any adult member of your assistance unit gets TANF/SFA;

(c) Any adult member of your assistance unit is not eligible for cash assistance for any reason unless one parent in a two-parent-assistance unit is receiving SSI; or

(d) Your assistance unit does not have a needy adult (such as when you do not receive TANF/SFA payment for yourself but receive it for the children only).

(8) If you apply for DCA after your TANF/SFA grant has been terminated, we consider you an applicant for DCA.

(9) If you apply for TANF/SFA and you received DCA less than twelve months ago:

(a) We set up a DCA loan.

(i) The amount of the loan is one-twelfth of the total DCA benefit times the number of months that are left in the twelve-month period.

(ii) The first month begins with the month DCA benefits began.

(b) We collect the loan only by reducing your grant. We take five percent of your TANF/SFA grant each month.

(10) If you stop getting TANF/SFA before you have repaid the loan, we stop collecting the loan unless you get back on TANF/SFA.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-24-064, § 388-432-0005, filed 11/30/10, effective 12/31/10. Statutory Authority: RCW 74.08.090, 74.04.-050. 01-03-066, § 388-432-0005, filed 1/12/01, effective 3/1/01.]

Chapter 388-436 WAC
EMERGENCY CASH ASSISTANCE

WAC

388-436-0015 Consolidated emergency assistance program (CEAP).
388-436-0020 CEAP assistance unit composition.
388-436-0030 Eligibility for CEAP depends on other possible cash benefits.

WAC 388-436-0015 Consolidated emergency assistance program (CEAP). (1) CEAP is available to the following:

(a) A pregnant woman in any stage of pregnancy; or

(b) Families with dependent children, including families who have stopped receiving their TANF grant under WAC 388-310-1600 so long as:

(i) The dependent child is living with a parent or a relative of specified degree as defined under WAC 388-454-0010; or

(ii) The dependent child has lived with such a relative within six months of the request for assistance.

(2) Applicants must be residents of Washington state as defined in WAC 388-468-0005.

(3) Applicants must demonstrate a financial need for emergency funds for one or more of the following basic requirements:

(a) Food;

(b) Shelter;

(c) Clothing;

(d) Minor medical care;

(e) Utilities;

(f) Household maintenance supplies;

(g) Necessary clothing or transportation costs to accept or retain a job; or

(h) Transportation for a minor, not in foster care, to a home where care will be provided by family members or approved caretakers.

(4) Payment under this program is limited to one time within twelve consecutive months for a period covering no more than thirty consecutive days.

(5) The department may discontinue program benefits issuances during periods of time when state funds appropriated for CEAP are exhausted.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.660. 11-02-037, § 388-436-0015, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 07-07-103, § 388-436-0015, filed 3/19/07, effective 4/19/07. Statutory Authority: RCW 74.04.050, 74.04.055, and 74.04.057. 04-05-013, § 388-436-0015, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0020 CEAP assistance unit composition. (1) The following persons living in the household must be included as members of the CEAP assistance unit:

(a) All full, half, or adopted siblings under eighteen years of age, including a minor parent; and

(b) The parent, adoptive parent, or stepparent living with the child or children.

(2) The following persons living in the household do not have to be included but may be included as members at the option of the applicant:

(a) One caretaker relative of specified degree when the child's parent does not live in the home;

(b) Stepbrothers or stepsisters to all children in the assistance unit.

(3) The following persons may make up a CEAP assistance unit without including others living in the home:

(a) The child of a parent who is a minor when the minor parent is not eligible due to the income and resources of his/her parents; or

(b) A pregnant woman when no other child is in the home.

(4) The following persons living in the household are not included as members of the CEAP assistance unit:

(a) A household member receiving Supplemental Security Income (SSI);

(b) A household member ineligible due to reasons stated in WAC 388-436-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.660. 11-02-037, § 388-436-0020, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0030 Eligibility for CEAP depends on other possible cash benefits. (1) You are ineligible for CEAP if you, or a household member, are eligible for any of the following programs:

(a) TANF or SFA, unless the family has had its case grant terminated due to WAC 388-310-1600 within the last six months;

(b) RCA;

(c) Disability lifeline (DL);

(d) Supplemental Security Income (SSI);

(e) Medical assistance for those applicants requesting help for a medical need;

(f) Food assistance for those applicants requesting help for a food need;

(g) Housing assistance from any available source for those applicants requesting help for a housing need;

(h) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(2) The department may require the applicant, or anyone in the assistance unit, to apply for and take any required action to receive benefits from programs described in the above subsection (1)(a) through (h).

(3) The department may not authorize CEAP benefits to any household containing a member who is:

(a) Receiving cash benefits from any of the following programs:

(i) TANF/SFA;

(ii) RCA;

(iii) DCA; or

(iv) DL.

(b) Receiving reduced cash benefits for failure to comply with program requirements of TANF/SFA, or RCA..

(4) The department may authorize CEAP to families reapplying for TANF/SFA who are not eligible for TANF cash benefits under WAC 388-310-1600 until they complete the four week participation requirement.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.660. 11-02-037, § 388-436-0030, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 07-07-103, § 388-436-0030, filed 3/19/07, effective 4/19/07. Statutory Authority: RCW 74.04.660. 99-24-130, § 388-436-0030, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0030, filed 7/31/98, effective 9/1/98.]

Chapter 388-438 WAC

EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

WAC

388-438-0110 Alien medical programs.

388-438-0115 Alien emergency medical program (AEM).

388-438-0120 Alien medical for dialysis and cancer treatment (state-only).

388-438-0125 Alien nursing facility program (state-funded).

WAC 388-438-0110 Alien medical programs. (1) To qualify for an alien medical program (AMP) a person must:

(a) Be ineligible for medicaid or other DSHS medical program due to the citizenship/alien status requirements described in WAC 388-424-0010;

(b) Meet the requirements described in WAC 388-438-0115, 388-438-0120, or 388-438-0125; and

(c) Meet categorical eligibility criteria for one of the following programs, except for the social security number or citizenship/alien status requirements:

(i) WAC 388-475-0050, for an SSI-related person;

(ii) WAC 388-505-0220, for family medical programs;

(iii) WAC 388-505-0210, for a child under the age of nineteen;

(iv) WAC 388-462-0015, for a pregnant woman;

(v) WAC 388-462-0020, for the breast and cervical cancer treatment program for women; or

(vi) WAC 388-523-0100, for medical extensions.

(2) AMP medically needy (MN) coverage is available for children, adults age sixty-five or over, or persons who meet SSI disability criteria. See WAC 388-519-0100 for MN eligibility and 388-519-0110 for spending down excess income under the MN program.

(3) The department does not consider a person's date of arrival in the United States when determining eligibility for AMP.

(4) The department does not consider a sponsor's income and resources when determining eligibility for AMP, unless the sponsor makes the income or resources available.

(5) A person is not eligible for AMP if that person entered the state specifically to obtain medical care.

(6) A person who the department determines is eligible for AMP may be eligible for retroactive coverage as described in WAC 388-416-0015.

(7) Once the department determines financial and categorical eligibility for AMP, the department then determines whether a person meets the requirements described in WAC 388-438-0115, 388-438-0120, or 388-438-0125.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0110, filed 9/17/10, effective 10/18/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 07-07-024, § 388-438-0110, filed 3/9/07, effective 4/9/07; 06-04-047, § 388-438-0110, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-438-0110, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 1903 (v)(2)(c) of the Social Security Act. 03-24-058, § 388-438-0110, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-438-0110, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and C.F.R. 436.128, 436.406(c) and 440.255. 01-05-041, § 388-438-0110, filed 2/14/01, effective 3/17/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 42 C.F.R. 435.139 and 42 C.F.R. 440.255. 99-23-082, § 388-438-0110, filed 11/16/99, effective 12/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

WAC 388-438-0115 Alien emergency medical program (AEM). (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) below, or (c) below:

(a) The department's health and recovery services administration determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 388-500-0005, and the condition is confirmed through review of clinical records; and

(b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:

(i) Inpatient;

(ii) Outpatient surgery;

(iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or

(c) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the department's inpatient mental health designee (see subsection (5) of this section).

(2) If a person meets the criteria in subsection (1), the department will cover and pay for all related medically necessary health care services and professional services provided:

(a) By a physician in his office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and

(b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:

(i) Medications;

(ii) Laboratory, X ray, and other diagnostics and the professional interpretations;

(iii) Medical equipment and supplies;

(iv) Anesthesia, surgical, and recovery services;

(v) Physician consultation, treatment, surgery, or evaluation services;

(vi) Therapy services;

(vii) Emergency medical transportation; and

(viii) Nonemergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the department as described in subsection (3) of this section.

(3) The department will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;

(b) The person is transferred directly to this facility from the hospital; and

(c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 388-550-2590 for LTAC and WAC 388-550-2561 for PM&R).

(4) The department does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the department under this program. Exception: Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 388-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the department's inpatient mental health designee according to the requirements in WAC 388-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.

(7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section. The exception for pharmacy services is also applicable as described in subsection (4) of this section.

(a) For inpatient care, the certification is only for the period of time the person is in the hospital, LTAC, or PM&R facility - the admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.

(b) For an outpatient surgery or emergency room service the certification is only for the date of service. If the person is in the hospital overnight, the certification will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is considered not within the scope of service categories as described in WAC 388-501-0060. This includes, but is not limited to:

(a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the department to be a qualifying emergency medical condition, including but not limited to:

(i) Laboratory X ray, or other diagnostic procedures;

(ii) Physical, occupational, speech therapy, or audiology services;

(iii) Hospital clinic services; or

(iv) Emergency room visits, surgery, or hospital admissions.

(b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to the treatment of the qualifying emergency medical condition;

(c) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;

(d) Services provided outside the hospital settings described in subsection (1) of this section, including but not limited to:

(i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;

(ii) Prenatal care, except labor and delivery;

(iii) Laboratory, radiology, and any other diagnostic testing;

(iv) School-based services;

(v) Personal care services;

(vi) Physical, respiratory, occupational, and speech therapy services;

(vii) Waiver services;

(viii) Nursing facility services;

(ix) Home health services;

(x) Hospice services;

(xi) Vision services;

(xii) Hearing services;

(xiii) Dental services;

(xiv) Durable and non durable medical supplies;

(xv) Nonemergency medical transportation;

(xvi) Interpreter services; and

(xvii) Pharmacy services, except as described in subsection (4).

(9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the department for visits or services that do not meet the qualifying criteria described in this section. The department will identify and recover payment for claims paid in error.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0115, filed 9/17/10, effective 10/18/10.]

WAC 388-438-0120 Alien medical for dialysis and cancer treatment (state-only). (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 may be eligible for the scope of service categories under this program if the condition requires:

(a) Surgery, chemotherapy, and/or radiation therapy to treat cancer;

(b) Dialysis to treat acute renal failure or end stage renal disease (ESRD); or

(c) Anti-rejection medication, if the person has had an organ transplant.

(2) When related to treating the qualifying medical condition, covered services include but are not limited to:

(a) Physician and ARNP services, except when providing a service that is not within the scope of this medical program (as described in subsection (7) of this section);

(b) Inpatient and outpatient hospital care;

(c) Dialysis;

(d) Surgical procedures and care;

(e) Office or clinic based care;

(f) Pharmacy services;

(g) Laboratory, X ray, or other diagnostic studies;

(h) Oxygen services;

(i) Respiratory and intravenous (IV) therapy;

(j) Anesthesia services;

(k) Hospice services;

(l) Home health services, limited to two visits;

(m) Durable and nondurable medical equipment;

(n) Nonemergency transportation; and

(o) Interpreter services.

(3) All hospice, home health, durable and nondurable medical equipment, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization. Any prior authorization requirements applicable to the other services listed above must also be met according to specific program rules.

(4) To be qualified and eligible for coverage for cancer treatment under this program, the diagnosis must be already established or confirmed. There is no coverage for cancer screening or diagnostics for a workup to establish the presence of cancer.

(5) Coverage for dialysis under this program starts the date the person begins dialysis treatment, which includes fistula placement and other required access. There is no coverage for diagnostics or predialysis intervention, such as surgery for fistula placement anticipating the need for dialysis, or any services related to preparing for dialysis.

(6) Certification for eligibility will range between one to twelve months depending on the qualifying condition, the proposed treatment plan, and whether the client is required to meet a spenddown liability.

(7) The following are not within the scope of service categories for this program:

(a) Cancer screening or work-ups to detect or diagnose the presence of cancer;

(b) Fistula placement while the person waits to see if dialysis will be required;

(c) Services provided by any healthcare professional to treat a condition not related to, or medically necessary to, treat the qualifying condition;

(d) Organ transplants, including preevaluations and post operative care;

(e) Health department services;

(f) School-based services;

(g) Personal care services;

(h) Physical, occupational, and speech therapy services;

(i) Audiology services;

(j) Neurodevelopmental services;

(k) Waiver services;

(l) Nursing facility services;

(m) Home health services, more than two visits;

(n) Vision services;

(o) Hearing services;

(p) Dental services, unless prior authorized and directly related to dialysis or cancer treatment;

(q) Mental health services;

(r) Podiatry services;

(s) Substance abuse services; and

(t) Smoking cessation services.

(8) The services listed in subsection (7) of this section are not within the scope of service categories for this program. The exception to rule process is not available.

(9) Providers must not bill the department for visits or services that do not meet the qualifying criteria described in this section.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0120, filed 9/17/10, effective 10/18/10.]

WAC 388-438-0125 Alien nursing facility program (state-funded). (1) The state-funded alien nursing facility program is subject to caseload limits determined by legislative funding. Services cannot be authorized for eligible persons prior to a determination by the aging and disability services administration (ADSA) that caseload limits will not be exceeded as a result of the authorization.

(2) To be eligible for the state-funded alien nursing facility program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a), (b), (e), and (f);

(b) Reside in a nursing facility as defined in WAC 388-97-0001;

(c) Attain institutional status as described in WAC 388-513-1320;

(d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

(e) Not have a penalty period due to a transfer of assets as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366;

(f) Not have equity interest in a primary residence of more than five hundred thousand dollars as described in WAC 388-513-1350; and

(g) Any annuities owned by the adult or spouse must meet the requirements described in chapter 388-561 WAC.

(3) An adult who is related to the supplemental security income (SSI) program as described in WAC 388-475-0050 (1), (2), and (3) must meet the financial requirements described in WAC 388-513-1325, 388-513-1330, and 388-513-1350.

(4) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC 388-505-0250 or 388-505-0255.

(5) An adult who is not eligible for the state-funded alien nursing facility program under categorically needy (CN) rules may qualify under medically needy (MN) rules described in:

(a) WAC 388-513-1395 for adults related to SSI; or

(b) WAC 388-505-0255 for adults related to family institutional medical.

(6) All adults qualifying for the state-funded alien nursing facility program will receive CN scope of medical coverage described in WAC 388-501-0060.

(7) The department determines how much an individual is required to pay toward the cost of care using the following rules:

(a) For an SSI-related individual, see rules described in WAC 388-513-1380.

(b) For an individual eligible under the family institutional program, see WAC 388-505-0265.

(8) A person is not eligible for state-funded nursing facility care if that person entered the state specifically to obtain medical care.

(9) A person eligible for the state-funded alien nursing facility program is certified for a twelve month period.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0125, filed 9/17/10, effective 10/18/10.]

Chapter 388-444 WAC
BASIC FOOD WORK REQUIREMENTS

WAC

388-444-0005	Am I required to work or look for work in order to be eligible for Basic Food?
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388-444-0075 What are the penalties if I quit a job without good cause?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-444-0020 When must clients register for work but are not required to participate in the food stamp employment and training program (FS E&T)? [Statutory Authority: RCW 74.04.510 and 74.04.050. 00-21-111, § 388-444-0020, filed 10/18/00, effective 11/18/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0020, filed 7/31/98, effective 9/1/98.] Repealed by 10-18-048, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7.

WAC 388-444-0005 Am I required to work or look for work in order to be eligible for Basic Food? Some people must register for work to receive Basic Food.

(1) If you receive Basic Food, we register you for work if you are:

(a) Age sixteen through fifty-nine with dependents;

(b) Age sixteen or seventeen, not attending secondary school and not the head-of-household;

(c) Age fifty through fifty-nine with no dependents; or

(d) Age eighteen through forty-nine, able-bodied and with no dependents as provided in WAC 388-444-0030.

(2) Unless you are exempt from work registration under WAC 388-444-0010, we register you for work:

(a) When you apply for Basic Food benefits or are added to someone's assistance unit; and

(b) Every twelve months thereafter.

(3) If we register you for work, you must:

(a) Contact us as required;

(b) Provide information regarding your employment status and availability for work if we ask for it;

(c) Report to an employer if we refer you;

(d) Not quit a job unless you have good cause under WAC 388-444-0070; and

(e) Accept a bona fide offer of suitable employment. We define unsuitable employment under WAC 388-444-0060.

(4) If we register you for work, you must meet all of the requirements under subsection (3) of this section. If you do not meet these requirements, we disqualify you from receiving benefits as described in WAC 388-444-0055, unless you meet the good cause conditions as defined in WAC 388-444-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7. 10-18-048, § 388-444-0005, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.903 and Food, Conservation and Energy Act of 2008. 09-04-009, § 388-444-0005, filed 1/22/09, effective 2/22/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.7 and 273.25. 07-14-125, § 388-444-0005, filed 7/3/07, effective 8/3/07; 06-24-026, § 388-444-0005, filed 11/29/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0010 Who is exempt from work registration while receiving Basic Food? If you receive Basic Food, you are exempt from work requirements in chapter 388-444 WAC if you meet any of the following conditions:

(1) You are age sixteen or seventeen, not the head of household, and:

(a) Attend school such as high school or GED programs; or

(b) Are enrolled at least half time (using the institutions definition) in an employment and training program under:

(i) The Workforce Investment Act (WIA);

(ii) Section 236 of the Trade Act of 1974; or

(iii) Another state or local employment and training program.

(2) You are a student age eighteen or older enrolled at least half time as defined by the institution in:

(a) Any accredited school;

(b) A training program; or

(c) An institution of higher education. If you are enrolled in higher education, you must meet the requirements under WAC 388-482-0005 to be eligible for Basic Food benefits.

(3) You are an employed or self-employed person working thirty hours or more per week, or receiving weekly earnings equal to the federal minimum wage multiplied by thirty;

(4) You are complying with the work requirements of an employment and training program under temporary assistance for needy families (TANF);

(5) You receive unemployment compensation (UC) benefits or have an application pending for UC benefits;

(6) You are responsible to care for:

(a) A dependent child under age six; or

(b) Someone who is incapacitated.

(7) We determine that you are physically or mentally unable to work; or

(8) You regularly participate in a drug addiction or alcoholic treatment and rehabilitation program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7. 10-18-048, § 388-444-0010, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0015 How can the Basic Food employment and training (BF E&T) program help me find work? The Basic Food employment and training (BF E&T) program is the name for Washington's voluntary supplemental nutrition assistance program (SNAP) employment and training program.

(1) If you receive federally-funded Basic Food benefits, you may choose to receive services through the BF E&T program in one or more of the following activities, if we currently provide the service in the county where you live:

(a) Job search;

(b) Paid or unpaid work;

(c) Training or work experience;

(d) General education development (GED) classes; or

(e) English as a second language (ESL) classes.

(2) If you are eligible to participate in a BF E&T activity, there is no limit to the number of hours you can participate.

(3) If you receive benefits under the state-funded food assistance program (FAP), you are not eligible to participate in BF E&T.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7. 10-18-048, § 388-444-0015, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 7 C.F.R. 273.7 and 273.25. 06-24-026, § 388-444-0015, filed 11/29/06, effective 1/1/07. Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0015, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0025 What expenses will the department pay to help me participate in BF E&T? (1) The department pays certain actual expenses needed for you to participate in the BF E&T program. We will pay for the following expenses:

(a) Transportation related costs; and

(b) Dependent care costs for each dependent through twelve years of age.

(2) We do not pay your dependent care costs if:

(a) The child is thirteen years of age or older unless they are:

(i) Physically and/or mentally unable to care for themselves; or

(ii) Under court order requiring adult supervision; or

(b) Any member in the food assistance unit provides the dependent care.

(3) We do not use the cost of dependent care the department pays for as an income deduction for your household's dependent care costs under WAC 388-450-0185.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7. 10-18-048, § 388-444-0025, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 07-21-075, § 388-444-0025, filed 10/16/07, effective 11/16/07; 98-16-044, § 388-444-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0030 Do I have to work to be eligible for Basic Food benefits if I am an able-bodied adult without dependents (ABAWD)? (1) An able-bodied adult without dependents (ABAWD) is a person who:

(a) Is physically and mentally able to work;

(b) Is age eighteen through forty-nine; and

(c) Has no child in the household.

(2) If you are an ABAWD, you must participate in employment and training activities under subsection (4) unless you are exempt from ABAWD requirements under WAC 388-444-0035.

(3) Nonexempt ABAWDs who fail to participate may continue to receive food assistance until September 30, 2011.

(4) Beginning October 1, 2011, an ABAWD is not eligible to receive food assistance for more than three full months in a thirty-six month period, except as provided in WAC 388-444-0035, unless that person:

(a) Is exempt from ABAWD requirements under WAC 388-444-0035;

(b) Works at least twenty hours a week averaged monthly;

(c) Participates in on the job training (OJT), which may include paid work and classroom training time, for at least twenty hours a week;

(d) Participates in an unpaid work program as provided in WAC 388-444-0040; or

(e) Participates in and meets the requirements of one of the following work programs:

(i) The job training partnership act (JTPA);

(ii) Section 236 of the trade act of 1974; or

(iii) A state-approved employment and training program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 C.F.R. §§ 273.7 and 273.24. 10-23-112, § 388-444-0030, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.04.500, 74.08A.120, and American Recovery and Reinvestment Act of 2009. 10-13-046, § 388-444-0030, filed 6/9/10, effective 7/10/10; 09-14-018, § 388-444-0030, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0035 Who is exempt from ABAWD work requirements? Some persons receiving Basic Food are exempt from ABAWD work requirements. You are exempt from the ABAWD requirements under WAC 388-444-0030 if you are:

(1) Under eighteen or fifty years of age or older;

(2) Determined to be physically or mentally unable to work;

(3) A member of a household with responsibility for a person who is incapacitated;

(4) An adult in a household that has a member who is under the age of eighteen, even if the child is not eligible for Basic Food;

(5) Pregnant;

(6) Living in an area approved as exempt by U.S. Department of Agriculture;

(7) Complying with the work requirements of an employment and training program under temporary assistance for needy families (TANF);

(8) Applying for or receiving unemployment compensation;

(9) A student enrolled at least half time as defined by the institution in:

(a) Any accredited school;

(b) Training program; or

(c) Institution of higher education. A student enrolled in higher education must meet the requirements under WAC 388-482-0005 in order to be eligible for Basic Food.

(10) Participating in a chemical dependency treatment and rehabilitation program;

(11) Employed a minimum of thirty hours per week or receiving weekly earnings which equal the minimum hourly rate multiplied by thirty hours;

(12) Eligible for one of the annual federal-approved exemption slots under the fifteen percent exemption rule.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 C.F.R. §§ 273.7 and 273.24. 10-23-112, § 388-444-0035, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050 and 74.04.510. 03-05-031, § 388-444-0035, filed 2/10/03, effective 4/1/03; 00-04-006, § 388-444-0035, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0035, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0040 Can I volunteer for an unpaid work program in order to meet the work requirements under WAC 388-444-0030? The department makes unpaid work programs available for persons who need to meet work requirements under WAC 388-444-0030.

(1) The following are considered unpaid work programs:

(a) Workfare, which includes:

(i) Thirty days of job search activities in the first month beginning with the first day of application, or sixteen hours of volunteer work with a public or private nonprofit agency; and

(ii) In subsequent months, sixteen hours per month of volunteer work with a public or private nonprofit agency allows you to remain eligible for Basic Food benefits.

(iii) Workfare does not include enforced community service or for paying fines or debts due to legal problems.

(b) Work experience (WEX) which provides supervised, unpaid work for at least twenty hours a week. WEX is intended to improve a person's work skills and make them more competitive in the job market. WEX must be for a nonprofit organization, government agency, or tribal entity.

(2) We may not **require** you to participate more than one hundred and twenty hours per month in an unpaid-work program, paid work, or a combination of activities. ABAWDs may volunteer to participate in activities beyond one hundred and twenty hours per month.

(3) The department may pay for some of the costs for you to participate in work programs. We set the standards for the amount we will pay for these expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 C.F.R. §§ 273.7 and 273.24. 10-23-112, § 388-444-0040, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.903 and Food, Conservation and Energy Act of 2008. 09-04-009, § 388-444-0040, filed 1/22/09, effective 2/22/09. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0040, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0045 How does an ABAWD regain eligibility for Basic Food after being closed for the three-month limit? (1) If you have used up your three months of benefits as an able-bodied adult without dependents (ABAWD) under WAC 388-444-0030, you can regain eligibility by:

(a) Working eighty hours or more during a thirty-day period;

(b) Participating in and meeting the requirements of a work program for eighty hours or more during a thirty-day period;

(c) Participating in and meeting the requirements of the community service part of a Workfare program; or

(d) Meeting any of the work requirements in (a) through (c) of this subsection in the thirty days after the date you have applied for Basic Food.

(2) If you regain eligibility for food assistance under subsection (1) of this section, you are eligible for Basic Food from the date you applied for Basic Food and as long as you continue to meet the requirements of WAC 388-444-0030.

(3) If you meet all other requirements for Basic Food and you have regained eligibility under subsection (1), you may receive an additional three consecutive months of Basic Food benefits when you:

(a) Lose employment; or

(b) Lose the opportunity to participate in a work program.

(4) We only allow the additional three months of Basic Food under subsection (3) once in each thirty-six month period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 C.F.R. §§ 273.7 and 273.24. 10-23-112, § 388-444-0045, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0045, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0050 What is good cause for failing to meet Basic Food work requirements? (1) If we have registered you to work, you may have a good reason (good cause) for refusing or failing to meet work requirements under WAC 388-444-0005.

(2) Good cause reasons include, but are not limited to:

(a) You were injured or ill;

(b) A household member who needs your help was injured or ill;

(c) A household emergency;

(d) The unavailability of transportation; or

(e) Lack of adequate dependent care for children six through twelve years of age.

(3) If we determine that you do not have good cause for failing or refusing to meet the work requirements under WAC 388-444-0005, you will be disqualified from receiving Basic Food as described under WAC 388-444-0055.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7. 10-18-048, § 388-444-0050, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0055 What are the penalties if I refuse or fail to meet Basic Food work requirements? (1) If we register you for work you must meet the work requirements under WAC 388-444-0005 or 388-444-0030 unless you have good cause as defined in WAC 388-444-0050. If you do not follow these rules, you will become an ineligible assistance unit member as described under WAC 388-408-0035. The remaining members of the assistance unit continue to be eligible for Basic Food.

(2) If you do not meet work requirements and we find that you did not have good cause, you cannot receive Basic Food for the following periods of time and until you meet program requirements:

(a) For the first failure, one month;

(b) For the second failure, three months; and

(c) For the third or subsequent failure, six months.

(3) If you become exempt under WAC 388-444-0010 and are otherwise eligible, you may begin to receive Basic Food.

(4) If you do not comply with the work requirements of the following programs, you cannot receive Basic Food unless you meet one of the conditions described under WAC 388-444-0010 except subsections (1)(d) or (e):

(a) WorkFirst;

(b) Unemployment compensation;

(c) The refugee cash assistance program.

(5) Within ten days after learning of your refusal to participate in your program, the financial worker will send you a notice that your Basic Food benefits will end unless you comply with your program requirements.

(6) If you do not comply within ten days, you will be issued a notice disqualifying you from receiving Basic Food until you comply with your program, or until you meet the work registration disqualification requirements in subsection (2) of this section.

(7) After the penalty period in subsection (2) of this section is over, and you meet work requirements and you are otherwise eligible, you may receive Basic Food:

(a) If you are alone in the assistance unit and apply to reestablish eligibility; or

(b) If you are a member of an assistance unit, you may resume receiving Basic Food.

(8) During the penalty period, if you begin to participate in one of the programs listed in subsection (4)(a) through (c) and that penalty is removed, the work registration disqualification also ends. If you are otherwise eligible, you may begin to receive Basic Food.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7. 10-18-048, § 388-444-0055, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-010, § 388-444-0055, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0055, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0060 What is unsuitable employment for Basic Food work requirements. If we register you for work, you must accept a bona fide offer of suitable employment in order to be eligible for Basic Food. We consider employment unsuitable when:

(1) The wage offered is less than the federal or state minimum wage, whichever is highest;

(2) The job offered is on a piece-rate basis and the average hourly yield expected is less than the federal or state minimum wage, whichever is highest;

(3) The employee, as a condition of employment, must join, resign from, or is barred from joining any legitimate labor union;

(4) The work offered is at a site subject to strike or lockout at the time of offer unless:

(a) The strike is enjoined under the Taft-Hartley Act; or

(b) An injunction is issued under section 10 of the Railway Labor Act.

(5) The employment has an unreasonable degree of risk to health and safety;

(6) You are physically or mentally unable to perform the job as documented by medical evidence or reliable information from other sources;

(7) The employment offered within the first thirty days of Basic Food work registration is not in your major field of experience;

(8) The distance from your home to the job is unreasonable considering the wage, time and cost of commute:

(a) The job is not suitable when daily commuting time exceeds two hours per day, not including transporting a child to and from child care; and

(b) The job is not suitable when the distance to the job prohibits walking and public or private transportation is not available.

(9) The working hours or nature of the job interferes with your religious observances, convictions, or beliefs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 U.S.C. 2015 (d)(1); 7 C.F.R. § 273.7. 10-18-048, § 388-444-0060, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0065 Am I eligible for Basic Food if I quit my job? (1) You are not eligible for Basic Food if you quit your current job without good cause as defined in WAC 388-444-0070, and you are in one of the following categories:

(a) You were working twenty hours or more per week or the job provided weekly earnings equal to the federal minimum wage multiplied by twenty hours;

(b) The quit was within sixty days before you applied for Basic Food or any time after;

(c) At the time of quit you were applying for Basic Food and would have been required to register for work as defined in WAC 388-444-0005;

(d) If you worked or you were self-employed and working thirty hours a week or you had weekly earnings at least equal to the federal minimum wage multiplied by thirty hours.

(2) You are not eligible to receive Basic Food if you have participated in a strike against a federal, state or local government and have lost your employment because of such participation.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 C.F.R. §§ 273.7 and 273.24. 10-23-112, § 388-444-0065, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0065, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0070 What is good cause for quitting my job? Unless otherwise specified the following rules apply to all persons receiving Basic Food.

(1) You must have a good reason (good cause) for quitting a job or you will be disqualified from receiving Basic Food under WAC 388-444-0075. Good cause includes the following:

(a) Your employment is unsuitable as under WAC 388-444-0060;

(b) You were discriminated against by an employer based on age, race, sex, color, religious belief, national origin, political belief, marital status, or the presence of any sensory, mental, or physical disability or other reasons in RCW 49.60.180;

(c) Work demands or conditions make continued employment unreasonable, such as working without being paid on schedule;

(d) You accepted other employment or are enrolled at least half time in any recognized school, training program, or institution of higher education;

(e) You must leave a job because another assistance unit member accepted a job or is enrolled at least half time in any recognized school, training program, or institution of higher education in another county or similar political subdivision and your assistance unit must move;

(f) You are under age sixty and retire as recognized by your employer;

(g) You accept a bona fide offer of employment of twenty hours or more a week or where the weekly earnings are equivalent to the federal minimum wage multiplied by twenty hours. However, because of circumstances beyond your control, the job either does not materialize or results in employment of twenty hours or less a week or weekly earnings of less than the federal minimum wage multiplied by twenty hours;

(h) You leave a job in connection with patterns of employment where workers frequently move from one employer to another, such as migrant farm labor or construction work; and

(i) Circumstances included under WAC 388-444-0050;

(2) You are eligible for Basic Food after quitting a job if the circumstances of the job involve:

(a) Changes in job status resulting from reduced hours of employment while working for the same employer;

(b) Termination of a self-employment enterprise; or

(c) Resignation from a job at the demand of an employer.

(3) You must provide proof that you had good cause for quitting a job. However, we do not deny your application for Basic Food if you are unable to get this proof even with our help.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 C.F.R. §§ 273.7 and 273.24. 10-23-112, § 388-444-0070, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0070, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0075 What are the penalties if I quit a job without good cause? (1) If you have applied for Basic Food and have quit a job without good cause within sixty days before applying for Basic Food, we deny your application and you must have a penalty period as described under subsection (3) from the date of your application.

(2) If you already receive Basic Food and you quit your job without good cause, we send you a letter notifying you that you will be disqualified from Basic Food. The disqualification in subsection (3) of this section begins the first of the month following the notice of adverse action.

(3) You are disqualified for the following minimum periods of time and until the conditions in subsection (4) of this section are met:

(a) For the first quit, one month;

(b) For the second quit, three months; and

(c) For the third or subsequent quit, six months.

(4) You may reestablish eligibility after serving the disqualification period, if otherwise eligible by:

(a) Getting a new job; or

(b) Participating in Workfare as provided in WAC 388-444-0040.

(5) If you become exempt from work registration under WAC 388-444-0010, we end your disqualification for a job quit unless you are exempt for applying for or receiving unemployment compensation (UC), or participating in an employment and training program under TANF.

(6) If you are disqualified and move from the assistance unit and join another assistance unit, we continue to treat you as an ineligible member of the new assistance unit for the remainder of the disqualification period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 C.F.R. §§ 273.7 and 273.24. 10-23-112, § 388-444-0075, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050 and 74.04.510. 01-05-006, § 388-444-0075, filed 2/7/01, effective 3/1/01; 00-04-006, § 388-444-0075, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0075, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-448 WAC
INCAPACITY

WAC

388-448-0010	How do we decide if you are incapacitated?
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388-448-0160	When do my disability lifeline benefits end?
388-448-0220	How does alcohol or drug dependence affect my eligibility for disability lifeline?
388-448-0250	Are there limits on the number of months I may receive disability lifeline benefits?

WAC 388-448-0010 How do we decide if you are incapacitated? When you apply for disability lifeline program benefits, you must provide medical evidence to us to show that you are unable to work.

If you are gainfully employed at the time of your application for DL, we deny incapacity. **"Gainful employment"** means you are performing, in a regular and predictable manner, an activity usually done for pay or profit.

(1) We don't consider work to be gainful employment when you are working:

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a sheltered workshop we have approved; or

(b) Occasionally or part-time because your impairment limits the hours you are able to work compared to unimpaired workers in the same job as verified by your employer.

(2) We determine if you are incapacitated when:

(a) You apply for disability lifeline benefits;

(b) You become employed;

(c) You obtain work skills by completing a training program; or

(d) We receive new information that indicates you may be employable.

(3) Unless you meet the other incapacity criteria in WAC 388-448-0001, we decide incapacity by applying the progressive evaluation process (PEP) to the medical evidence that you provide that meets WAC 388-448-0030. The PEP is the sequence of seven steps described in WAC 388-448-0035 through 388-448-0110.

(4) If you have a physical or mental impairment and you are impaired by alcohol or drug addiction and do not meet the other incapacity criteria in WAC 388-448-0001, we decide if you are eligible for disability lifeline by applying the progressive evaluation process described in WAC 388-448-0035 through WAC 388-448-0110. You aren't eligible for DL benefits if you are incapacitated primarily because of alcoholism or drug addiction.

(5) In determining incapacity, we consider only your ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: Sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating, and understanding and following instructions.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096 and 10-21-001, § 388-448-0010, filed 7/30/10 and 10/6/10, effective 9/1/10 and 11/6/10. Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0010, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0010, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0030 What medical evidence do I need to provide? You must provide medical evidence that clearly shows you have an impairment and how that impairment prevents you from being capable of gainful employment. Medical evidence must be in writing and be clear, objective and complete.

(1) Objective evidence for physical impairments means:

(a) Laboratory test results;

(b) Pathology reports;

(c) Radiology findings including results of X rays and computer imaging scans;

(d) Clinical finding, including but not limited to ranges of joint motion, blood pressure, temperature or pulse; and documentation of a physical examination; or

(e) Hospital history and physical reports and admission and discharge summaries; or

(f) Other medical history and physical reports related to your current impairments.

(2) Objective evidence for mental impairments means:

(a) Clinical interview observations, including objective mental status exam results and interpretation.

(b) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) Hospital, outpatient and other treatment records related to your current impairments.

(d) Testing results, if any, including:

(i) Description and interpretation of tests of memory, concentration, cognition or intelligence; or

(ii) Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.

Medical evidence sufficient for an incapacity determination must be from a medical professional described in WAC 388-448-0020 and must include:

(a) A diagnosis for the impairment, or impairments, based on an examination performed within twelve months of application;

(b) A clear description of how the impairment relates to your ability to perform the work-related activities listed in WAC 388-448-0010(5);

(c) Documentation of how the impairment, or impairments, is currently limiting your ability to work based on an examination performed within the ninety days of the date of application or the forty-five days before the month of incapacity review; and

(d) Facts in addition to objective evidence to support the medical provider's opinion that you are unable to be gainfully employed, such as proof of hospitalization.

(4) When making an incapacity decision, we do not use your report of symptoms as evidence unless objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.

(5) We don't use symptoms related to substance abuse or a diagnosis of addiction or chemical dependency when determining incapacity.

(6) We consider diagnoses that are independent of addiction or chemical dependency when determining incapacity.

(7) We determine you have a diagnosis that is independent of addiction or chemical dependency if the impairment will persist at least ninety days after you stop using drugs or alcohol.

(8) If you can't obtain medical evidence of an impairment that prevents you from working without cost to you and you meet the eligibility conditions other than incapacity in WAC 388-400-0025, we pay the costs to obtain objective evidence based on our published payment limits and fee schedules.

(9) We decide incapacity based solely on the objective information we receive. We are not obligated to accept a decision that you are incapacitated or unemployable made by another agency or person.

(10) We can't use a statement from a medical professional to determine that you are incapacitated unless the statement is supported by objective medical evidence.

[Statutory Authority: RCW 74.08.090, 74.04.005, 74.04.050, 74.04.055, and 74.04.057. 10-08-025, § 388-448-0030, filed 3/31/10, effective 5/1/10. Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0030, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0030, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0040 PEP step I—Review of medical evidence required for eligibility determination. When we receive your medical evidence, we review it to see if it is sufficient to decide whether your circumstances meet incapacity requirements.

(1) We require a written medical report to determine incapacity. The report must:

(a) Contain sufficient information as described under WAC 388-448-0030;

(b) Be written by an authorized medical professional described in WAC 388-448-0020;

(c) Document the existence of a potentially incapacitating condition; and

(d) Indicate an impairment is expected to last ninety days or more from the application date.

(2) If the information received isn't clear, we may require more information before we decide your ability to be gainfully employed. As examples, we may require you to get more medical tests or be examined by a medical specialist.

(3) We deny incapacity if:

(a) There is only one impairment and the severity rating is less than three;

(b) A reported impairment isn't expected to last ninety days (twelve weeks) or more from the date of application;

(c) The only impairment supported by objective medical evidence is drug or alcohol addiction; or

(d) We don't have clear and objective medical evidence to approve incapacity.

[Statutory Authority: RCW 74.08.090, 74.04.005, 74.04.050, 74.04.055, and 74.04.057. 10-08-025, § 388-448-0040, filed 3/31/10, effective 5/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0040, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0050 PEP step II—How we determine the severity of mental impairments. If you are diagnosed with a mental impairment by a professional described in WAC 388-448-0020, we use information from the provider to determine how the impairment limits work-related activities.

(1) We review the following psychological evidence to determine the severity of your mental impairment:

(a) Psychosocial and treatment history records;

(b) Clinical findings of specific abnormalities of behavior, mood, thought, orientation, or perception;

(c) Results of psychological tests; and

(d) Symptoms observed by the examining practitioner that show how your impairment affects your ability to perform basic work-related activities.

(2) We exclude diagnosis and related symptoms of alcohol or substance abuse or addiction;

(3) If you are diagnosed with mental retardation, the diagnosis must be based on the Wechsler Adult Intelligence Scale (WAIS). The following test results determine the severity rating:

Intelligence Quotient (IQ) Score	Severity Rating
85 or above	None (1)
71 to 84	Moderate (3)
70 or lower	Severe (5)

(4) If you are diagnosed with a mental impairment with physical causes, we assign a severity rating based on the most severe of the following four areas of impairment:

(a) Short term memory impairment;

(b) Perceptual or thinking disturbances;

(c) Disorientation to time and place; or

(d) Labile, shallow, or coarse affect.

(5) We base the severity of an impairment diagnosed as a mood, thought, memory, or cognitive disorder on a clinical assessment of the intensity and frequency of symptoms that:

(a) Affect your ability to perform basic work related activities; and

(b) Are consistent with a diagnosis of a mental impairment as listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

(6) We base the severity rating for a functional mental impairment on accumulated severity ratings for the symptoms in subsection (5)(a) of this section as follows:

Symptom Ratings or Condition	Severity Rating
(a) You are diagnosed with a functional disorder with psychotic features; (b) You have had two or more hospitalizations for psychiatric reasons in the past two years; (c) You have had more than six months of continuous psychiatric inpatient or residential treatment in the past two years; (d) The objective evidence and global assessment of functional score are consistent with a significant limitation on performing work activities.	Moderate (3)
(e) The objective evidence and global assessment of functioning score are consistent with very significant limitations on ability to perform work activities.	Marked (4)
(f) The objective evidence and global assessment of functioning score are consistent with the absence of ability to perform work activities.	Severe (5)

(7) If you are diagnosed with any combination of mental retardation, mental impairment with physical causes, or functional mental impairment, we assign a severity rating as follows:

Condition	Severity Rating
(a) Two or more disorders with moderate severity (3) ratings; or (b) One or more disorders rated moderate severity (3); and one rated marked severity (4).	Marked (4)
(c) Two or more disorders rated marked severity (4).	Severe (5)

(8) We deny incapacity when you haven't been diagnosed with a significant physical impairment and your overall mental severity rating is one or two;

(9) We approve incapacity when you have an overall mental severity rating of severe (five).

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 10-20-089, § 388-448-0050, filed 9/30/10, effective 11/1/10; 10-08-036, § 388-448-0050, filed 3/31/10, effective 5/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 09-11-078, § 388-448-0050, filed 5/18/09, effective 6/18/09; 00-16-113, § 388-448-0050, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0080 PEP step V—How we determine your ability to function in a work environment if you have a mental impairment. If you have a mental impairment we evaluate your cognitive and social functioning in a work setting. Functioning means your ability to perform typical tasks that would be required in a routine job setting and your ability to interact effectively while working.

(1) We evaluate cognitive and social functioning by assessing your ability to:

(a) Understand, remember, and persist in tasks by following simple instructions of one or two steps.

(b) Understand, remember, and persists in tasks by following complex instructions of three or more steps.

(c) Learn new tasks.

(d) Perform routine tasks without undue supervision.

(e) Be aware of normal hazards and take appropriate precautions.

(f) Communicate and perform effectively in a work setting with public contact.

(g) Communicate and perform effectively in a work setting with limited public contact.

(h) Maintain appropriate behavior in a work setting.

(2) We approve incapacity when we have objective medical evidence, including a mental status exam (MSE) per WAC 388-448-0050, that demonstrates you are:

(a) At least moderately impaired in your ability to understand, remember, and persist in tasks following simple instructions, and at least moderately limited in your ability to:

(i) Learn new tasks;

(ii) Be aware of normal hazards and take appropriate precautions; and

(iii) Perform routine tasks without undue supervision; or

(b) At least moderately impaired in the ability to understand, remember, and persist in task following complex instructions; and

(c) Markedly impaired in the ability to learn new tasks, be aware of normal hazards and take appropriate precautions, and perform routine tasks without undue supervision.

(3) We approve incapacity when you are moderately (rated three) impaired in your ability to:

(a) Communicate and perform effectively in a work setting with public contact;

(b) Communicate and perform effectively in a work setting with limited public contact; and

(c) Markedly (rated four) impaired in your ability to maintain appropriate behavior in a work setting.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 10-20-089, § 388-448-0080, filed 9/30/10, effective 11/1/10; 10-08-036, § 388-448-0080, filed 3/31/10, effective 5/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0080, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0090 PEP step V—How we determine your ability to function in a work environment if you have a physical impairment. In Step V of the PEP we review the medical evidence you provide and make a determination of how your physical impairment prevents you from working. This determination is then used in Steps VI and VII of the PEP to determine your ability to perform either work you have done in the past or other work.

(1) **"Exertion level"** means having strength, flexibility, and mobility to lift, carry, stand or walk as needed to fulfill job duties in the following work levels. For this section, "occasionally" means less than one-third of the time and "frequently" means one-third to two-thirds of the time.

The following table is used to determine your exertion level. Included in this table is a strength factor, which is your ability to perform physical activities, as defined in Appendix C of the Dictionary of Occupational Titles (DOT), Revised Edition, published by the U.S. Department of Labor as posted on the Occupational Information Network (O*NET).

If you are able to:	Then we assign this exertion level
(a) Lift no more than two pounds or unable to stand or walk.	Severely limited
(b) Lift ten pounds maximum and frequently lift or carry lightweight articles. Walking or standing only for brief periods.	Sedentary
(c) Lift twenty pounds maximum and frequently lift or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday. Sitting and using pushing or pulling arm or leg movements most of the day.	Light
(d) Lift fifty pounds maximum and frequently lift or carry up to twenty-five pounds.	Medium
(e) Lift one hundred pounds maximum and frequently lift or carry up to fifty pounds.	Heavy

(2) **"Exertionally related limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. If you have exertionally related limitations, we consider them in determining your ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility you can apply to work-related activities. We consider the effect of the physical impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. We determine functional physical capacity based on your exertional, exertionally related and nonexertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Examples are:

(a) Environmental restrictions which could include, among other things, your inability to work in an area where you would be exposed to chemicals; and

(b) Workplace restrictions, such as impaired hearing or speech, which would limit the types of work environments you could work in.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 10-20-089, § 388-448-0090, filed 9/30/10, effective 11/1/10;

10-08-036, § 388-448-0090, filed 3/31/10, effective 5/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0090, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0100 PEP step VI—How we evaluate capacity to perform relevant past work. If your overall severity rating is moderate (three) or marked (four) and we have reached this stage of the PEP and have not approved or denied your application, we decide if you can do the same or similar work as you have done in the past. We look at your current physical and/or mental limitations from cognitive, social, and vocational factors to make this decision. Vocational factors are education, relevant work history, and age.

(1) We evaluate education in terms of formal schooling or other training to acquire skills that enables you to meet job requirements. We classify education as:

If you	Then your education level is
(a) Can't read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Have no formal schooling or vocational training beyond the eleventh grade; or (c) Had participated in special education in basic academic classes of reading, writing, or mathematics in high school.	Limited education
(d) Have received a high school diploma or general equivalency degree (GED); or (e) Have received skills training and were awarded a certificate, degree or license.	High school and above level of education

(2) We evaluate your work experience to determine if you have relevant past work. "Relevant past work" means work:

(a) Defined as gainful employment per WAC 388-448-0010;

(b) Has been performed in the past five years;

(c) You performed long enough to acquire the knowledge and skills to continue performing the job. You must meet the specific vocational preparation level as defined in Appendix C of the Dictionary of Occupational Titles.

(3) For each relevant past work situation you have had, we determine:

(a) The exertional or skill requirements of the job.

(b) Current cognitive, social, or nonexertional factors that significantly limit your ability to perform past work.

(4) After considering vocational factors, we deny incapacity when you have:

(a) The physical and mental ability to perform past work, and there is no significant cognitive, social or nonexertional limitation that would prevent you from performing past work; or

(b) Recently acquired specific work skills through completion of schooling or training, for jobs within your current physical or mental capacities.

(5) We approve incapacity when you are fifty-five years of age or older and don't have the physical or mental ability to perform past work.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 10-20-089, § 388-448-0100, filed 9/30/10, effective 11/1/10; 10-08-036, § 388-448-0100, filed 3/31/10, effective 5/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0100, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0110 PEP step VII—How we evaluate your capacity to perform other work. If we decide you cannot do work that you've done before, we then decide if you can do any other work.

(1) We approve incapacity if you have a physical impairment and meet the vocational factors below:

Highest work level assigned by the practitioner	Your age	Your education level	Other vocational factors
Sedentary	Any age	Any level	Does not apply
Light	Fifty and older	Any level	Does not apply
Light	Thirty-five and older	Illiterate or limited English proficiency (LEP)	Does not apply
Light	Eighteen and older	Limited education	Does not have any past work
Medium	Fifty and older	Limited education	Does not have any past work

(2) We approve incapacity when you have a (moderate three) or marked (four) mental health impairment and we have objective medical evidence, including a mental status exam (MSE) per WAC 388-448-0050, that demonstrates social or cognitive factors described in WAC 388-448-0080, interfere with working as follows:

Social limitation	Age
(a) Moderately impaired (rated three) in your ability to: (i) Communicate and perform effectively in a work setting with limited public contact; and (ii) Maintain appropriate behavior in a work setting.	Fifty years and older

Social limitation	Age
(b) You have a severe (five) impairment in your ability to: (i) Communicate and perform effectively in a work setting with public contact; or (ii) Communicate and perform effectively in a work setting with limited public contact.	Any age
(c) A mental disorder of marked severity (rated four); (i) One or more severe (rated five) mental impairment symptoms; and (ii) Moderately impaired (rated three) in the ability to communicate and perform effectively in a work setting with public or limited public contact.	Any age

(3) We approve incapacity when you have both mental and physical impairments and we have objective medical evidence, including a mental status exam (MSE) per WAC 388-448-0050, that demonstrate social or cognitive factors, as described in WAC 388-448-0080 interfere with working as follows:

Your age	Your education	Your other restrictions
Any age	Any level	(a) You are moderately impaired in your ability to communicate and perform effectively in a work setting with limited public contact; and (b) You are markedly impaired in your ability to communicate and perform effectively in a work setting with public contact.
Fifty or older	Limited education	(c) Restricted to medium work level or less.
Any age	Limited education	(d) Restricted to light work level.

(4) We deny incapacity if we decide you don't meet the criteria listed above.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 10-20-089, § 388-448-0110, filed 9/30/10, effective 11/1/10; 10-08-036, § 388-448-0110, filed 3/31/10, effective 5/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0110, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0130 Treatment and referral requirements. We refer you for medical treatment or to other agencies for services, rehabilitation, or work activities when we decide medical treatment or services are available, and will improve your ability to become gainfully employed or reduce your need for disability lifeline benefits. **"Medical treatment"** means any medical, surgical, mental health service, or any other treatment or service recommended by a medical or mental health provider.

(1) When you are first approved, and at each review determination, we give you written information regarding your medical treatment and agency referral requirements.

(2) You must accept and follow through on required medical treatment and referrals to other agencies and services, unless you have good cause for not doing so. Good cause for medical treatment and referrals is defined in WAC 388-448-0140.

(3) You may request an administrative hearing if you disagree with the medical treatment or agency referral requirements we set for you (see WAC 388-458-0040).

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096, § 388-448-0130, filed 7/30/10, effective 9/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0130, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0130, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0140 When does a person have good cause for refusing or failing to participate in medical treatment or referrals to other agencies? When you refuse or fail to participate in required medical treatment or referrals to other agencies, you may claim good cause by providing a reason for your refusal or failure. We determine whether your reason is valid. We may require you to provide proof to support your good cause claim. These rules do not apply to participation requirements listed in WAC 388-448-0200 through 388-448-0250.

(1) Valid reasons for refusing or failing to participate in medical treatment:

(a) You are so fearful of the treatment that your fear could interfere with the treatment or reduce its benefits;

(b) The treatment provider has identified a risk that the treatment may cause further limitations or loss of a function or an organ and you are not willing to take that risk;

(c) You practice an organized religion that prohibits the treatment; or

(d) We determine that treatment is not available because you can't obtain it without cost to you.

(2) Valid reasons for refusing or failing to participate in referrals to other agencies:

(a) You are unable to participate because we didn't give you enough information about the requirement;

(b) You didn't receive written notice of the requirement;

(c) The requirement was made in error;

(d) You provide proof of interference beyond your control that temporarily prevented you from participating; or

(e) Your medical condition or limitations are consistent with the need for necessary supplemental accommodation (NSA), as defined in WAC 388-472-0020 and contributed to your refusal or failure, per WAC 388-472-0050.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096, § 388-448-0140, filed 7/30/10, effective 9/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0140, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0140, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0150 Penalty for refusing or failure to participate in medical treatment or other agency referrals. (1) If you refuse or fail to participate in required medical treatment or agency referral without having good cause, we will terminate your disability lifeline benefits.

(2) You are ineligible for cash and medical benefits until you participate in:

(a) Chemical dependency treatment as required under WAC 388-448-0220.

(b) Obtaining federal aid assistance as required under WAC 388-448-0200.

(3) If we terminate your disability lifeline benefits because you didn't have good cause to refuse, or fail to participate in, other required medical treatment services or referrals to other agencies, you are not eligible for cash and medical benefits until you verify that you have agreed to accept and pursue the medical treatment service or referral to other agencies.

(4) If you reapply for disability lifeline, you must participate as described in subsection (2) and (3) and wait for a penalty period to pass before you begin receiving benefits. The penalty is based on how often you have refused:

Refusal	Penalty
First	One week
Second within six months	One month
Third and subsequent within one year	Two months

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096, § 388-448-0150, filed 7/30/10, effective 9/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0150, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0160 When do my disability lifeline benefits end? (1) The maximum period of eligibility for disability lifeline is twelve months before we must review incapacity.

(a) We use current medical evidence and the expected length of time before you are capable of gainful employment to decide when your benefits will end.

(b) If you meet the incapacity criteria in WAC 388-448-0001 (1)(a) through (e), you must provide information about your cooperation and progress with treatment or agency referrals we required according to WAC 388-448-0130.

(2) Your benefits stop at the end of your incapacity period unless you provide additional medical evidence that demonstrates during your current incapacity period that there was no material improvement in your impairment. No material improvement means that your impairment continues to meet the progressive evaluation process criteria in WAC 388-448-0010 through 388-448-0110, excluding the requirement that your impairment(s) prevent employment for ninety days.

(3) The medical evidence must meet all of the criteria defined in WAC 388-448-0030.

(4) We use medical evidence received after your incapacity period had ended when:

(a) The delay was not due to your failure to cooperate; and

(b) We receive the evidence within thirty days of the end of your incapacity period; and

(c) The evidence meets the progressive evaluation process criteria in WAC 388-448-0010 through 388-448-0110.

(5) Even if your condition has not improved, you aren't eligible for disability lifeline when:

(a) We receive current medical evidence that doesn't meet the progressive evaluation process criteria in WAC 388-448-0035 through 388-448-0110; and

(b) Our prior decision that your incapacity met the requirements was incorrect because:

(i) The information we had was incorrect or not sufficient to show incapacity; or

(ii) We didn't apply the rules correctly to the information we had at that time.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096, § 388-448-0160, filed 7/30/10, effective 9/1/10. Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0160, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0160, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0220 How does alcohol or drug dependence affect my eligibility for disability lifeline? (1) You must complete a chemical dependency assessment when we have information that indicates you may be chemically dependent.

(2) You must accept an assessment referral and participate in drug or alcohol treatment if a certified chemical dependency counselor indicates a need for treatment, unless you meet one of the following good cause reasons:

(a) We determine that your physical or mental health impairment prevents you from participating in treatment.

(b) The outpatient chemical dependency treatment you need isn't available in the county you live in.

(c) You need inpatient chemical dependency treatment at a location that you can't reasonably access.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096, § 388-448-0220, filed 7/30/10, effective 9/1/10.]

WAC 388-448-0250 Are there limits on the number of months I may receive disability lifeline benefits? (1) Beginning September 1, 2010, you may be eligible to receive disability lifeline benefits for a maximum of twenty-four out of any sixty month period.

(2) You aren't subject to a benefit month limit if:

(a) You are aged sixty-five or older;

(b) Blind as defined in WAC 388-475-0050; or

(c) We have determined you meet, or are likely to meet, the federal Supplemental Security Income (SSI) disability standard.

(3) We count months you received general assistance or disability lifeline benefits in the last sixty months towards your maximum benefit limit.

(4) We don't count any benefit month that you were determined to meet the criteria in subsection (2) towards your maximum benefit limit.

(5) We will review your case record to determine if you are likely to meet the federal SSI disability standard before we terminate your benefits.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.51 [74.04.510], 74.08.090, 74.08A.100, 74.04.770, 74.04.0005 [74.04.005], and 2010 c 8. 10-16-096, § 388-448-0250, filed 7/30/10, effective 9/1/10.]

Chapter 388-450 WAC
INCOME

WAC

388-450-0015 What types of income does the department not use to figure out my benefits?
388-450-0040 Native American benefits and payments.
388-450-0050 How does your participation in the community jobs (CJ) program affect your cash assistance and Basic Food benefits?
388-450-0080 What is self-employment income?
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388-450-0190 How does the department figure my shelter cost income deduction for Basic Food?
388-450-0195 Does the department use my utility costs when calculating my Basic Food or WASHCAP benefits?

WAC 388-450-0015 What types of income does the department not use to figure out my benefits? This section applies to cash assistance, children's, family, or pregnancy medical, and basic food benefits.

(1) There are some types of income we do not count to figure out if you can get benefits and the amount you can get. Some examples of income we do not count are:

(a) Bona fide loans as defined in WAC 388-470-0045, except certain student loans as specified under WAC 388-450-0035;

(b) Federal earned income tax credit (EITC) payments;

(c) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(d) Federal twenty-five dollar supplemental weekly unemployment compensation payment authorized by the American Recovery and Reinvestment Act of 2009;

(e) Title IV-E and state foster care maintenance payments if you choose not to include the foster child in your assistance unit;

(f) Energy assistance payments;

(g) Educational assistance we do not count under WAC 388-450-0035;

(h) Native American benefits and payments we do not count under WAC 388-450-0040;

(i) Income from employment and training programs we do not count under WAC 388-450-0045;

(j) Money withheld from a benefit to repay an overpayment from the same income source. For Basic Food, we **do not** exclude money that is withheld because you were overpaid for purposely not meeting requirements of a federal, state, or local means tested program such as TANF/SFA, GA, and SSI;

(k) Legally obligated child support payments received by someone who gets TANF/SFA benefits;

(l) One-time payments issued under the Department of State or Department of Justice Reception and Replacement Programs, such as Voluntary Agency (VOLAG) payments; and

(m) Payments we are directly told to exclude as income under state or federal law.

(n) **For cash and Basic Food:** Payments made to someone outside of the household for the benefits of the assistance unit using funds that are not owed to the household;

(o) **For Basic Food only:** The total monthly amount of all legally obligated current or back child support payments paid by the assistance unit to someone outside of the assistance unit for:

(i) A person who is not in the assistance unit; or

(ii) A person who is in the assistance unit to cover a period of time when they were not living with the member of the assistance unit responsible for paying the child support on their behalf.

(p) **For medical assistance:** Only the portion of income used to repay the cost of obtaining that income source.

(2) For children's, family, or pregnancy medical, we also do not count any insurance proceeds or other income you have recovered as a result of being a Holocaust survivor.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and Worker, Homeownership, and Business Assistance Act of 2009. 10-17-103, § 388-450-0015, filed 8/17/10, effective 8/19/10. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and P.L. 107-171, section 4101. 09-15-085 and 09-16-095, § 388-450-0015, filed 7/14/09 and 8/4/09, effective 11/15/09. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 74.08.090. 09-09-103, § 388-450-0015, filed 4/20/09, effective 4/21/09; 06-07-078, § 388-450-0015, filed 3/13/06, effective 5/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and Public Law 106-419. 05-03-078, § 388-450-0015, filed 1/17/05, effective 2/17/05. Statutory Authority: RCW 74.08.090 and 74.04.510. 02-14-022, § 388-450-0015, filed 6/21/02, effective 6/22/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 2000 2nd sp.s. c 1 § 210(12). 01-18-006, § 388-450-0015, filed 8/22/01, effective 9/22/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0015, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0040 Native American benefits and payments. This section applies to TANF/SFA, RCA, GA medical and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;

(e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-

41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and

(f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

(a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;

(b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540;(c) Payments under the Seneca Nation Settlement Act, P.L. 101-503; and

(d) For medical assistance, receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of protected resources, such as fishing, shell-fishing, or selling timber, is considered conversion of an exempt resource during the month of receipt. Any amounts remaining from the conversion of this exempt resource on the first of the month after the month of receipt will remain exempt if the funds were used to purchase another exempt resource. Any amounts remaining in the form of countable resources (such as in checking or savings accounts) on the first of the month after receipt, will be added to other countable resources for eligibility determinations.

[Statutory Authority: RCW 74.08.090 and ARRA of 2009, Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-450-0040, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140.]

WAC 388-450-0050 How does your participation in the community jobs (CJ) program affect your cash assistance and Basic Food benefits? (1) There are two different types of income in the community jobs program. They are:

(a) Subsidized, where your wages are paid from TANF or SFA funds; and

(b) Unsubsidized, where your wages are paid entirely by your employer.

(2) We figure your total monthly subsidized or unsubsidized income by:

(a) Estimating the number of hours you, your case manager, and the CJ contractor expect you to work for the month; and

(b) Multiplying the number of hours by the federal or state minimum wage, whichever is higher.

(3) Because you are expected to participate and meet the requirements of CJ, once we determine what your total monthly income is expected to be, we do not change your TANF grant if your actual hours are more or less than anticipated.

(4) We treat the total income we expect you to get each month from your CJ position as:

(a) Earned income for cash assistance, except we do not count any of the CJ income for the first month you receive your paycheck.

(b) Earned income for Basic Food for all months.

(5) If your anticipated subsidized income is more than your grant amount, your cash grant is suspended. This means that you are still considered a TANF/SFA recipient, but you do not get a grant.

(a) Your grant can be suspended up to a maximum of nine months.

(b) You can keep participating in CJ even though your grant is suspended, as long as you would be eligible for a grant if we did not count your subsidized income.

(c) The months your grant is suspended do not count toward your sixty-month lifetime limit.

(6) If your unsubsidized income, after we subtract half of what you have earned is greater than your grant, your TANF/SFA case will close. This happens because your income is over the maximum you are allowed. You will still be able to participate in the CJ program for up to a total of nine months.

(7) If your income from other sources alone, not counting CJ income makes you ineligible for a cash grant, we terminate your grant and end your participation in CJ.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340, 74.04.055, 74.04.057, 74.04.500, 74.04.510. 10-22-012, § 388-450-0050, filed 10/21/10, effective 2/1/11. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340. 04-14-043, § 388-450-0050, filed 6/29/04, effective 7/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 03-06-095, § 388-450-0050, filed 3/4/03, effective 5/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510. 01-23-044, § 388-450-0050, filed 11/15/01, effective 1/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-09-054, § 388-450-0050, filed 4/19/99, effective 6/1/99; 98-16-044, § 388-450-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0080 What is self-employment income? This section applies to cash assistance, Basic Food, and medical programs for children, pregnant women and families.

(1) Self-employment income is income you earn from running a business, performing a service, selling items you make, or reselling items to make a profit.

(2) You are self-employed if you earn income without having an employer/employee relationship with the person who pays you. This includes, but is not limited to, when:

(a) You have primary control of the way you do your work; or

(b) You report your income using IRS Schedule C, Schedule C-EZ, Schedule K-1, or Schedule SE.

(3) You usually have an employer/employee relationship when:

(a) The person you provide services for has primary control of how you do your work; or

(b) You get an IRS form W-2 to report your income.

(4) Your self-employment does not have to be a licensed business for your business or activity to qualify as self-employment. Some examples of self-employment include:

(a) Child care that requires a license under chapter 74.15 RCW;

(b) Driving a taxi cab;

(c) Farming/fishing;

(d) Odd jobs such as mowing lawns, house painting, gutter cleaning, or car care;

(e) Running a lodging for roomers and/or boarders. Roomer income includes money paid to you for shelter costs by someone not in your assistance unit who lives with you when:

(i) You own or are buying your residence; or

(ii) You rent all or a part of your residence and the total rent you charge all others in your home is more than your total rent.

(f) Running an adult family home;

(g) Providing services such as a massage therapist or a professional escort;

(h) Retainer fees to reserve a bed for a foster child;

(i) Selling items you make or items that are supplied to you;

(j) Selling or donating your own biological products such as providing blood or reproductive material for profit;

(k) Working as an independent contractor; and

(l) Running a business or trade either on your own or in a partnership.

(5) For medical programs, we do not count receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of exempt resources as self-employment income (such as fishing, shellfishing, or selling timber from protected tribal land). We count this as conversion of a resource. See WAC 388-450-0040.

(6) If you are an employee of a company or person who does the activities listed in subsection (2) above as a part of your job, we do not count the work you do as self-employment.

(7) Self-employment income is counted as earned income as described in WAC 388-450-0030 except as described in subsection (8).

(8) For cash assistance and Basic Food there are special rules about renting or leasing out property or real estate that you own.

(a) We count the income you get as unearned income unless you spend at least twenty hours per week managing the property.

(b) For TANF/SFA, we count the income as unearned income unless the use of the property is a part of your approved individual responsibility plan.

[Statutory Authority: RCW 74.08.090 and ARRA of 2009, Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-450-0080, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-15-049, § 388-450-0080, filed 7/12/06, effective 9/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-13-045, § 388-450-0080, filed 6/11/03, effective 8/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-19-020, § 388-450-0080, filed 9/11/01, effective 10/1/01; 99-16-024, § 388-450-0080, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0080, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0140 How does the income of an ineligible assistance unit member affect my eligibility and benefits for Basic Food? The department decides who must be in your assistance unit (AU) under WAC 388-408-0035. If an AU member is ineligible for Basic Food under WAC 388-408-0035, this affects your AU's eligibility and benefits as follows:

(1) We do not count the ineligible member(s) to determine your AU size for the gross monthly income limit, net monthly income limit, or maximum allotment under WAC 388-478-0060.

(2) If an AU member is ineligible because they are disqualified for an intentional program violation (IPV), they failed to meet work requirements under chapter 388-444 WAC, or they are ineligible fleeing felons under WAC 388-442-0010:

(a) We count all of the ineligible member's gross income as a part of your AU's income; and

(b) We count all of the ineligible member's allowable expenses as part of your AU's expenses.

(3) If an AU member is an ineligible ABAWD under WAC 388-444-0030, is ineligible due to their alien status, failed to sign the application to state their citizenship or alien status, or refused to get or provide us a Social Security number:

(a) We allow the twenty percent earned income disregard for the ineligible member's earned income;

(b) We prorate the remaining income of the ineligible member among all the AU members by excluding the ineligible member's share and counting the remainder to the eligible members; and

(c) We divide the ineligible member's allowable expenses evenly among all members of the AU when the ineligible member has income except that we do not divide the standard utility allowance (SUA). We allow the full SUA based on the total number of members in your AU.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 U.S.C. 2014 (e)(7); 7 C.F.R. § 273.9 (d)(6). 10-15-044, § 388-450-0140, filed 7/13/10, effective 8/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-14-040, § 388-450-0140, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 02-06-089, § 388-450-0140, filed 3/1/02, effective 3/26/02; 01-21-060, § 388-450-0140, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0140, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0140, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0156 When am I exempt from deeming? (1) If you meet any of the following conditions, you are **permanently** exempt from deeming and we do not count your sponsor's income or resources against your benefits:

(a) The Immigration and Nationality Act (INA) does not require you to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with Immigration and Naturalization Service (INS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban entrant; or

(v) Haitian entrant.

(b) You were sponsored by an organization or group as opposed to an individual;

(c) You do not meet the alien status requirements to be eligible for benefits under chapter 388-424 WAC;

(d) You have worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. We do not count a quarter of work toward this requirement if the person working received TANF, food stamps, Basic Food, SSI, CHIP, or nonemergency medicaid benefits. We count a quarter of work by the following people toward your forty qualifying quarters:

(i) Yourself;

(ii) Each of your parents for the time they worked before you turned eighteen years old (including the time they worked before you were born); and

(iii) Your spouse if you are still married or your spouse is deceased.

(e) You become a United States (U.S.) Citizen;

(f) Your sponsor is dead; or

(g) If INS or a court decides that you, your child, or your parent was a victim of domestic violence from your sponsor and:

(i) You no longer live with your sponsor; and

(ii) Leaving your sponsor caused your need for benefits.

(2) You are exempt from the deeming process while you are in the same AU as your sponsor;

(3) For Basic Food, you are exempt from deeming while you are under age eighteen.

(4) For state family assistance, general assistance, state-funded Basic Food benefits, and state-funded medical assistance for legal immigrants you are exempt from the deeming process if:

(a) Your sponsor signed the affidavit of support more than five years ago;

(b) Your sponsor becomes permanently incapacitated; or

(c) You are a qualified alien according to WAC 388-424-0001 and you:

(i) Are on active duty with the U.S. armed forces or you are the spouse or unmarried dependent child of someone on active duty;

(ii) Are an honorably-discharged veteran of the U.S. armed forces or you are the spouse or unmarried dependent child of a honorably-discharged veteran;

(iii) Were employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Are a victim of domestic violence and you have petitioned for legal status under the Violence Against Women Act.

(5) If you, your child, or your parent was a victim of domestic violence, you are exempt from the deeming process for twelve months if:

(a) You no longer live with the person who committed the violence; and

(b) Leaving this person caused your need for benefits.

(6) If your AU has income at or below one hundred thirty percent of the federal poverty level (FPL), you are exempt from the deeming process for twelve months. This is called the "indigence exemption." You may choose to use this exemption or not to use this exemption in full knowledge of the possible risks involved. See risks in subsection (9) below. For this rule, we count the following as income to your AU:

(a) Earned and unearned income your AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services you receive from an individual or organization.

(7) If you use the indigence exemption, and are eligible for a federal program, we are required by law to give the United States attorney general the following information:

(a) The names of the sponsored people in your AU;

(b) That you are exempt from deeming due to your income;

(c) Your sponsor's name; and

(d) The effective date that your twelve-month exemption began.

(8) If you use the indigence exemption, and are eligible for a state program, we do not report to the United States attorney general.

(9) If you choose not to use the indigence exemption:

(a) You could be found ineligible for benefits for not verifying your sponsor's income and resources; or

(b) You will be subject to regular deeming rules under WAC 388-450-0160.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 U.S.C. 2014(i); 7 C.F.R. § 273.4(c); USDA Food and Nutrition Service final rules for the FSRIA of 2002 (farm bill) final rule announcement. 10-15-043, § 388-450-0156, filed 7/13/10, effective 8/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-450-0156, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-030, § 388-450-0156, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0156, filed 10/9/01, effective 11/1/01.]

WAC 388-450-0160 How does the department decide how much of my sponsor's income to count against my benefits? (1) We must count some of your sponsor's income as unearned income to your assistance unit (AU) if:

(a) Your sponsor signed the INS affidavit of support form I-864 or I-864A; and

(b) You are not exempt from the deeming process under WAC 388-450-0156.

(2) We take the following steps to decide the monthly amount of your sponsor's income we deem as your income and count against your benefits:

(a) We start with your sponsor's earned and unearned income that is not excluded under WAC 388-450-0015;

(b) If your sponsor's spouse signed the affidavit of support, we add all of the spouse's earned and unearned income that is not excluded under WAC 388-450-0015;

(c) We subtract twenty percent of the above amount that is earned income under WAC 388-450-0030;

(d) For cash and medical assistance, we subtract the need standard under WAC 388-478-0015. We count the following people who live in your sponsor's home as a part of your sponsor's AU to decide the need standard:

(i) Your sponsor;

(ii) Your sponsor's spouse; and

(iii) Everyone else in their home that they could claim as a dependent for federal income tax purposes.

(e) For food assistance, we subtract the maximum gross monthly income under WAC 388-478-0060. We count the following people that live in your sponsor's home as a part of your sponsor's AU to decide the maximum gross monthly income:

(i) Your sponsor;

(ii) Your sponsor's spouse; and

(iii) Everyone else in their home that they could claim as a dependent for federal income tax purposes.

(f) If you can show that your sponsor has sponsored other people as well, we divide the result by the total number

of people who they sponsored including any member of your household that is exempt from deeming according to WAC 388-450-0156.

(3) After we have decided how much income to deem to you, we count the greater amount of the following against your benefits:

(a) The amount of income calculated from deeming; or

(b) The amount of money your sponsor actually gives you for your needs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 U.S.C. 2014(i); 7 C.F.R. § 273.4(c); USDA Food and Nutrition Service final rules for the FSRIA of 2002 (farm bill) final rule announcement. 10-15-043, § 388-450-0160, filed 7/13/10, effective 8/1/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0160, filed 10/9/01, effective 11/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0160, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0160, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0185 What income deductions does the department allow when determining if I am eligible for food benefits and the amount of my monthly benefits? We determine if your assistance unit (AU) is eligible for Basic Food and calculate your monthly benefits according to requirements of the Food and Nutrition Act of 2008 and federal regulations related to the supplemental nutrition assistance program (SNAP).

These federal laws allow us to subtract **only** the following amounts from your AU's total monthly income to determine your countable monthly income under WAC 388-450-0162:

(1) A standard deduction based on the number of eligible people in your AU under WAC 388-408-0035:

Eligible AU members	Standard deduction
1	$142
2	$142
3	$142
4	$153
5	$179
6 or more	$205

(2) Twenty percent of your AU's gross earned income (earned income deduction);

(3) Your AU's expected monthly dependent care expense needed for an AU member to:

(a) Keep work, look for work, or accept work;

(b) Attend training or education to prepare for employment; or

(c) Meet employment and training requirements under chapter 388-444 WAC.

(4) Medical expenses over thirty-five dollars a month owed or anticipated by an elderly or disabled person in your AU as allowed under WAC 388-450-0200.

(5) A portion of your shelter costs as described in WAC 388-450-0190.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 10-23-114, § 388-450-0185, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 U.S.C. 2014 (a) and (e)(1); 7 C.F.R. §§ 273.1 and 273.9 (d)(1). 10-16-104, § 388-450-0185, filed 8/2/10, effective 9/2/10. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and P.L. 107 - 171 § 4101. 09-23-004, § 388-450-0185, filed 11/5/09, effective 11/15/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and Food and Nutrition Act of 2008, Title 7 Part 273 of the C.F.R. 09-07-054, § 388-450-0185, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 08-24-051, § 388-450-0185, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-450-0185, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-450-0185, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-450-0185, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0185, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-450-0185, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and H.R. 2646 Farm Security and Rural Investment Act of 2002. 02-22-044, § 388-450-0185, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0185, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0185, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0190 How does the department figure my shelter cost income deduction for Basic Food? The department calculates your shelter cost income deduction as follows:

(1) First, we add up the amounts your assistance unit (AU) must pay each month for shelter. We do not count any overdue amounts, late fees, penalties or mortgage payments you make ahead of time as an allowable cost. We count the following expenses as an allowable shelter cost in the month the expense is due:

(a) Monthly rent, lease, and mortgage payments;

(b) Property taxes;

(c) Homeowner's association or condo fees;

(d) Homeowner's insurance for the building only;

(e) Utility allowance your AU is eligible for under WAC 388-450-0195;

(f) Out-of-pocket repairs for the home if it was substantially damaged or destroyed due to a natural disaster such as a fire or flood;

(g) Expense of a temporarily unoccupied home because of employment, training away from the home, illness, or abandonment caused by a natural disaster or casualty loss if your:

(i) AU intends to return to the home;

(ii) AU has current occupants who are not claiming the shelter costs for Basic Food purposes; and

(iii) AU's home is not being leased or rented during your AU's absence.

(2) Second, we subtract all deductions your AU is eligible for under WAC 388-450-0185 (1) through (5) from your AU's gross income. The result is your AU's net income.

(3) Finally, we subtract one-half of your AU's net income from your AU's total shelter costs. The result is your excess shelter costs. Your AU's shelter cost deduction is the excess shelter costs:

(a) Up to a maximum of four hundred fifty-eight dollars if no one in your AU is elderly or disabled; or

(b) The entire amount if an eligible person in your AU is elderly or disabled, even if the amount is over four hundred fifty-eight dollars.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 10-23-114, § 388-450-0190, filed 11/17/10, effective 12/18/10; 09-24-001, § 388-450-0190, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-24-050, § 388-450-0190, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-450-0190, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-450-0190, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-450-0190, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0190, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-07-138, § 388-450-0190, filed 3/22/04, effective 5/1/04; 03-21-030, § 388-450-0190, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057, 74.08.090. 02-22-045, § 388-450-0190, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0190, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-06-030, § 388-450-0190, filed 3/2/01, effective 4/2/01; 99-16-024, § 388-450-0190, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0190, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0195 Does the department use my utility costs when calculating my Basic Food or WASHCAP benefits? (1) We use a standard utility allowance (SUA) of three hundred eighty-five dollars instead of your actual utility costs when we determine your assistance unit's:

(a) Monthly benefits under WAC 388-492-0070 if you receive WASHCAP; or

(b) Shelter cost income deduction under WAC 388-450-0190 for Basic Food.

(2) We considered the average cost of the following utilities to determine the value of the SUA:

(a) Heating and cooling fuel such as electricity, oil, or gas;

(b) Electricity;

(c) Water and sewer;

(d) Well or septic tank installation/maintenance;

(e) Garbage/trash collection; and

(f) Telephone service.

(3) The department uses the SUA if you have utility costs separate from your rent or mortgage payment or if you receive a low income home energy assistance program (LIHEAP) benefit during the year.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. § 273.9 (d)(6)(3). 10-18-050, § 388-450-0195, filed 8/26/10, effective 10/1/10. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 09-24-001, § 388-450-0195, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 08-21-106, § 388-450-0195, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-036, § 388-450-0195, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-450-0195, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-10-056, § 388-450-0195, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. § 273.9. 05-19-062, § 388-450-0195, filed 9/16/05, effective 10/17/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-09-087, § 388-450-0195, filed 4/19/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0195, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-450-0195, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-22-045, § 388-450-0195, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0195, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.510. 00-22-065, § 388-450-0195, filed 10/27/00, effective 11/1/00. Statutory Authority: RCW 74.040.510 [74.04.510]. 99-24-052, § 388-450-0195, filed 11/29/99, effective 12/1/99. Statutory Authority: RCW 74.04.510. 99-09-055, § 388-450-0195, filed 4/19/99, effective 5/20/99. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6). 99-01-069, § 388-450-0195, filed 12/14/98, effective 1/14/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0195, filed 7/31/98, effective 9/1/98.]

Chapter 388-455 WAC
LUMP SUM INCOME

WAC

388-455-0005 How do lump sum payments affect benefits?
388-455-0015 When and how does the department treat lump sum payments as income for cash assistance and family medical programs?

WAC 388-455-0005 How do lump sum payments affect benefits? (1) A lump sum payment is money that someone receives but does not expect to receive on a continuing basis.

(2) For cash assistance and family medical programs, we count a lump sum payment:

(a) As a resource, under WAC 388-455-0010, if it was awarded for wrongful death, personal injury, damage, or loss of property.

(b) As income, under WAC 388-455-0015, if it was received for any other reason, with the exception of subsection (3) of this section.

(3) For medical programs, receipt of a lump sum by a member of a federally recognized tribe from exercising federally protected rights or extraction of exempt resources is considered an exempt resource in the month of receipt. Any amounts remaining on the first of the next month will be counted if they remain in the form of a countable resource. Any amounts remaining the first of the month after conversion will remain exempt if they are in the form of an exempt resource.

(4) For Basic Food, we count lump sum payments for a previous period as a resource under WAC 388-470-0055. We count any amount for current or future months as income to your assistance unit.

[Statutory Authority: RCW 74.08.090 and ARRA of 2009, Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-455-0005, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-11-105, § 388-455-0005, filed 5/20/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0005, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0015 When and how does the department treat lump sum payments as income for cash assistance and family medical programs? This section applies to cash and family medical programs.

(1) If you receive a lump sum payment that is not awarded for wrongful death, personal injury, damage, or loss of property, we count this payment as income to your assistance unit. We budget this income according to effective date rules under WAC 388-418-0020.

(2) For cash assistance, if you cannot access some or all of your lump sum payment for reasons beyond your control, we will adjust the amount we count as income to your assistance unit as described under WAC 388-450-0005.

(3) To decide the amount of your lump sum we count as income, we take the following steps:

(a) First, we subtract the value of your current resources from the resource limit under WAC 388-470-0005;

(b) Then, we subtract the difference in (3)(a) from the total amount of the lump sum; and

(c) The amount left over is what we count as income, as specified in WAC 388-450-0025 and 388-450-0030.

(4) When the countable amount of the lump sum payment is:

(a) Less than your payment standard plus additional requirements, we count it as income in the month it is received.

(b) More than one month's payment standard plus additional requirements but less than two months:

(i) We count the portion equal to one month's payment standard plus additional requirements as income in the month it is received; and

(ii) We count the remainder as income the following month.

(c) Equal to or greater than the total of the payment standard plus additional requirements for the month of receipt and the following month, we count the payment as income for those months.

(5) If you receive a one-time lump sum payment, and you are ineligible or disqualified from receiving cash benefits:

(a) We allocate the payment to meet your needs as described under WAC 388-450-0105; and

(b) Count the remainder as a lump sum payment available to eligible members of your assistance unit according to the rules of this section.

(6) For family medical programs:

(a) We count lump sum payments as income in the month you receive the payment.

(b) We count lump sums received by a member of a federally recognized tribe for exercising federally protected rights or extraction of exempt resources as an exempt resource in the month of receipt. Any amount remaining the first of the next month in the form of an exempt resource will remain exempt. Any amount remaining the first of the month will be countable if in the form of a countable resource.

(c) If you cannot access some or all of your lump sum payment for reasons beyond your control, will adjust the amount we count as income to your assistance unit as described under WAC 388-450-0005.

(d) We count any money that remains on the first of the next month as a resource except for recipients as described in WAC 388-470-0026 (1) and (2).

[Statutory Authority: RCW 74.08.090 and ARRA of 2009, Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-455-0015, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-11-105, § 388-455-0015, filed 5/20/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0015, filed 11/19/99, effective 1/1/00.]

Chapter 388-470 WAC
RESOURCES

WAC
388-470-0045 How do my resources count toward the resource limits for cash assistance and family medical programs?

WAC 388-470-0045 How do my resources count toward the resource limits for cash assistance and family medical programs? (1) We count the following resources toward your assistance unit's resource limits for cash assistance and family medical programs to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources not specifically excluded in subsection (2) below. These are resources that are easily changed into cash. Some examples of liquid resources are:

(i) Cash on hand;

(ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Available retirement funds or pension benefits, less any withdrawal penalty;

(v) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(vi) Available trusts or trust accounts;

(vii) Lump sum payments as described in chapter 388-455 WAC; or

(viii) Any funds retained beyond the month of receipt from conversion of federally protected rights or extraction of exempt resources by members of a federally recognized tribe that are in the form of countable resources.

(b) The cash surrender value (CSV) of whole life insurance policies.

(c) The CSV over fifteen hundred dollars of revocable burial insurance policies or funeral agreements.

(d) The amount of a child's irrevocable educational trust fund that is over four thousand dollars per child.

(e) Funds withdrawn from an individual development account (IDA) if they were removed for a purpose other than those specified in RCW 74.08A.220.

(f) Any real property like a home, land or buildings not specifically excluded in subsection (3) below.

(g) The equity value of vehicles as described in WAC 388-470-0070.

(h) Personal property that is not:

(i) A household good;

(ii) Needed for self-employment; or

(iii) Of "great sentimental value," due to personal attachment or hobby interest.

(i) Resources of a sponsor as described in WAC 388-470-0060.

(j) For cash assistance only, sales contracts.

(2) The following types of liquid resources do not count when we determine your eligibility:

(a) Bona fide loans, including student loans;

(b) Basic Food benefits;

(c) Income tax refunds in the month of receipt;

(d) Earned income tax credit (EITC) in the month received and the following month;

(e) Advance earned income tax credit payments;

(f) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(g) Individual development accounts (IDAs) established under RCW 74.08A.220;

(h) Retroactive cash benefits or TANF/SFA benefits resulting from a court order modifying a decision of the department;

(i) Underpayments received under chapter 388-410 WAC;

(j) Educational benefits that are excluded as income under WAC 388-450-0035;

(k) The income and resources of an SSI recipient;

(l) A bank account jointly owned with an SSI recipient if SSA already counted the money for SSI purposes;

(m) Foster care payments provided under Title IV-E and/or state foster care maintenance payments;

(n) Adoption support payments;

(o) Self-employment accounts receivable that the client has billed to the customer but has been unable to collect;

(p) Resources specifically excluded by federal law; and

(q) For medical benefits, receipts from exercising federally protected rights or extracted exempt resources (fishing, shell-fishing, timber sales, etc.) during the month of receipt for a member of a federally recognized tribe.

(3) The following types of real property do not count when we determine your eligibility:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) You are making a good faith effort to sell;

(ii) You intend to build a home on, if you do not already own a home;

(iii) Produces income consistent with its fair market value, even if used only on a seasonal basis; or

(iv) A household member needs for employment or self-employment. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(d) Indian lands held jointly with the tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs.

(4) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit.

(5) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on your new home is taking longer than anticipated;

(ii) You are unable to find a new home that you can afford;

(iii) Someone in your household is receiving emergent medical care; or

(iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

[Statutory Authority: RCW 74.08.090 and ARRA of 2009, Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-470-0045, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 74.08.090. 09-09-103, § 388-470-0045, filed 4/20/09, effective 4/21/09. Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0045, filed 2/7/03, effective 3/1/03; 99-16-024, § 388-470-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0045, filed 7/31/98, effective 9/1/98.]

Chapter 388-475 WAC
SSI-RELATED MEDICAL AND (HWD) PROGRAM

WAC

388-475-0350 SSI-related medical—Property and contracts excluded as resources.
388-475-0400 SSI-related medical—Vehicles excluded as resources.
388-475-0550 SSI-related medical—All other excluded resources.
388-475-0600 SSI-related medical—Definition of income.

WAC 388-475-0350 SSI-related medical—Property and contracts excluded as resources. (1) The department does not count the following resources when determining eligibility for SSI-related medical assistance:

(a) A client's household goods and personal effects;

(b) One home (which can be any shelter), including the land on which the dwelling is located and all contiguous property and related out-buildings in which the client has ownership interest, when:

(i) The client uses the home as his or her primary residence; or

(ii) The client's spouse lives in the home; or

(iii) The client does not currently live in the home but the client or his/her representative has stated the client intends to return to the home; or

(iv) A relative, who is financially or medically dependent on the client, lives in the home and the client, client's representative, or dependent relative has provided a written statement to that effect.

(c) The value of ownership interest in jointly owned real property is an excluded resource for as long as sale of the property would cause undue hardship to a co-owner due to loss of housing. Undue hardship would result if the co-owner:

(i) Uses the property as his or her principal place of residence;

(ii) Would have to move if the property were sold; and

(iii) Has no other readily available housing.

(2) Cash proceeds from the sale of the home described in subsection (1)(b) above are not considered if the client uses them to purchase another home by the end of the third month after receiving the proceeds from the sale.

(3) An installment contract from the sale of the home described in subsection (1)(b) above is not a resource as long as the person plans to use the entire down payment and the

entire principal portion of a given installment payment to buy another excluded home, and does so within three full calendar months after the month of receiving such down payment or installment payment.

(4) The value of sales contracts is excluded when the:

(a) Current market value of the contract is zero,

(b) Contract cannot be sold, or

(c) Current market value of the sales contract combined with other resources does not exceed the resource limits.

(5) Sales contracts executed before December 1, 1993, are exempt resources as long as they are not transferred to someone other than a spouse.

(6) A sales contract for the sale of the client's principal place of residence executed between December 1, 1993 and May 31, 2004 is considered an exempt resource unless it has been transferred to someone other than a spouse and it:

(a) Provides interest income within the prevailing interest rate at the time of the sale;

(b) Requires the repayment of a principal amount equal to the fair market value of the property; and

(c) The term of the contract does not exceed thirty years.

(7) A sales contract executed on or after June 1, 2004 on a home that was the principal place of residence for the client at the time of institutionalization is considered exempt as long as it is not transferred to someone other than a spouse and it:

(a) Provides interest income within the prevailing interest rate at the time of the sale;

(b) Requires the repayment of a principal amount equal to the fair market value of the property within the anticipated life expectancy of the client; and

(c) The term of the contract does not exceed thirty years.

(8) Payments received on sales contracts of the home described in subsection (1)(b) above are treated as follows:

(a) The interest portion of the payment is treated as unearned income in the month of receipt of the payment;

(b) The principal portion of the payment is treated as an excluded resource if reinvested in the purchase of a new home within three months after the month of receipt;

(c) If the principal portion of the payment is not reinvested in the purchase of a new home within three months after the month of receipt, that portion of the payment is considered a liquid resource as of the date of receipt.

(9) Payments received on sales contracts described in subsection (4) are treated as follows:

(a) The principal portion of the payment on the contract is treated as a resource and counted toward the resource limit to the extent retained at the first moment of the month following the month of receipt of the payment; and

(b) The interest portion is treated as unearned income the month of receipt of the payment.

(10) For sales contracts that meet the criteria in subsections (5), (6), or (7) but do not meet the criteria in subsections (3) or (4), both the principal and interest portions of the payment are treated as unearned income in the month of receipt.

(11) Property essential to self-support is not considered a resource within certain limits. The department places property essential to self-support in several categories:

(a) Real and personal property used in a trade or business (income-producing property), such as:

(i) Land,

(ii) Buildings,

(iii) Equipment,

(iv) Supplies,

(v) Motor vehicles, and

(vi) Tools.

(b) Nonbusiness income-producing property, such as:

(i) Houses or apartments for rent, or

(ii) Land, other than home property.

(c) Property used to produce goods or services essential to an individual's daily activities, such as land used to produce vegetables or livestock, which is only used for personal consumption in the individual's household. This includes personal property necessary to perform daily functions including vehicles such as boats for subsistence fishing and garden tractors for subsistence farming, but does not include other vehicles such as those that qualify as automobiles (cars, trucks).

(12) The department will exclude an individual's equity in real and personal property used in a trade or business (income producing property listed in subsection (11)(a) above) regardless of value as long as it is currently in use in the trade or business and remains used in the trade or business.

(13) The department excludes up to six thousand dollars of an individual's equity in nonbusiness income-producing property listed in subsection (11)(b) above, if it produces a net annual income to the individual of at least six percent of the excluded equity.

(a) If a person's equity in the property is over six thousand dollars, only the amount over six thousand dollars is counted toward the resource limit, as long as the net annual income requirement of six percent is met on the excluded equity.

(b) If the six percent requirement is not met due to circumstances beyond the person's control, and there is a reasonable expectation that the activities will again meet the six percent rule, the same exclusions as in subsection (13)(a) above apply.

(c) If a person has more than one piece of property in this category, each is looked at to see if it meets the six percent return and the total equities of all those properties are added to see if the total is over six thousand dollars. If the total is over the six thousand dollars limit, the amount exceeding the limit is counted toward the resource limit.

(d) The equity in each property that does not meet the six percent annual net income limit is counted toward the resource limit, with the exception of property that represents the authority granted by a governmental agency to engage in an income-producing activity if it is:

(i) Used in a trade or business or nonbusiness income-producing activity; or

(ii) Not used due to circumstances beyond the individual's control, e.g., illness, and there is a reasonable expectation that the use will resume.

(14) Property used to produce goods or services essential to an individual's daily activities is excluded if the individual's equity in the property does not exceed six thousand dollars.

(15) Personal property used by an individual for work is not counted, regardless of value, while in current use, or if the required use for work is reasonably expected to resume.

(16) Interests in trust or in restricted Indian land owned by an individual who is of Indian descent from a federally recognized Indian tribe or held by the spouse or widow/er of that individual, is not counted if permission of the other individuals, the tribe, or an agency of the federal government must be received in order to dispose of the land.

(17) Receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of exempt resources, such as fishing, shell-fishing, or selling timber from protected land, is considered conversion of an exempt resource during the month of receipt. Any amount remaining from the conversion of this exempt resource on the first of the month after the month of receipt will remain exempt if it is used to purchase another exempt resource. Any amount remaining in the form of a countable resource (such as in a checking or savings account) on the first of the month after receipt, will be added to other countable resources for eligibility determinations.

[Statutory Authority: RCW 74.08.090 and ARRA of 2009, Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-475-0350, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0350, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0400 SSI-related medical—Vehicles excluded as resources. (1) For SSI-related medical programs, a vehicle is defined as anything used for transportation. In addition to cars and trucks, a vehicle can include boats, snowmobiles, and animal-drawn vehicles.

(2) One vehicle is excluded regardless of its value, if it is used to provide transportation for the disabled individual or a member of the individual's household.

(3) For an SSI-related institutional client with a community spouse, one vehicle is excluded regardless of its value or its use. See WAC 388-513-1350 (7)(b).

(4) A vehicle used as the client's primary residence is excluded as the home, and does not count as the one excluded vehicle under subsection (2) or (3).

(5) All other vehicles, except those excluded under WAC 388-475-0350 (11) through (14), are treated as nonliquid resources and the equity value is counted toward the resource limit.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 10-13-077, § 388-475-0400, filed 6/15/10, effective 7/16/10. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0400, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0550 SSI-related medical—All other excluded resources. All resources described in this section are excluded resources for SSI-related medical programs. Unless otherwise stated, interest earned on the resource amount is counted as unearned income.

(1) Resources necessary for a client who is blind or disabled to fulfill a department approved self-sufficiency plan.

(2) Retroactive payments from SSI or RSDI, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, are excluded for nine months following the month of receipt. This exclusion applies to:

(a) Payments received by the client, spouse, or any other person financially responsible for the client;

(b) SSI payments for benefits due for the month(s) before the month of continuing payment;

(c) RSDI payments for benefits due for a month that is two or more months before the month of continuing payment; and

(d) Proceeds from these payments as long as they are held as cash, or in a checking or savings account. The funds may be commingled with other funds, but must remain identifiable from the other funds for this exclusion to apply. This exclusion does not apply once the payments have been converted to any other type of resource.

(3) All resources specifically excluded by federal law, such as those described in subsections (4) through (12) as long as such funds are identifiable.

(4) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

(5) Payments made to Native Americans as listed in 20 CFR 416.1182, Appendix to subpart K, section IV, paragraphs (b) and (c), and in 20 CFR 416.1236.

(6) The following Native American/Alaska Native funds are excluded resources:

(a) Resources received from a native corporation under the Alaska Native Claims Settlement Act, including:

(i) Shares of stock held in a regional or village corporation;

(ii) Cash or dividends on stock received from the native corporation up to two thousand dollars per person per year;

(iii) Stock issued by a native corporation as a dividend or distribution on stock;

(iv) A partnership interest;

(v) Land or an interest in land; and

(vi) An interest in a settlement trust.

(b) All funds contained in a restricted individual Indian money (IIM) account.

(7) Exercise of federally protected rights, including extraction of exempt resources by a member of a federally recognized tribe during the month of receipt. Any funds from the conversion of the exempt resource which are retained on the first of the month after the month of receipt will be considered exempt if they are in the form of an exempt resource, and will be countable if retained in the form of a countable resource.

(8) Restitution payment and any interest earned from this payment to persons of Japanese or Aleut ancestry who were relocated and interned during war time under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act.

(9) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims.

(10) Payments or interest accrued on payments received under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(11) Payments or interest accrued on payments received under the Energy Employees Occupational Illness Compensation Act of 2000 (EEOICA) received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(12) Payments from:

(a) The Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV).

(b) The Victims of Nazi Persecution Act of 1994 to survivors of the Holocaust.

(c) Susan Walker vs. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds.

(d) Ricky Ray Hemophilia Relief Fund Act of 1998 P.L. 105-369.

(13) The unspent social insurance payments received due to wage credits granted under sections 500 through 506 of the Austrian General Social Insurance Act.

(14) Earned income tax credit refunds and payments are excluded as resources for nine months after the month of receipt.

(15) Payments from a state administered victim's compensation program for a period of nine calendar months after the month of receipt.

(16) Cash or in-kind items received as a settlement for the purpose of repairing or replacing a specific excluded resource are excluded:

(a) For nine months. This includes relocation assistance provided by state or local government.

(b) Up to a maximum of thirty months, when:

(i) The client intends to repair or replace the excluded resource; and

(ii) Circumstances beyond the control of the settlement recipient prevented the repair or replacement of the excluded resource within the first or second nine months of receipt of the settlement.

(c) For an indefinite period, if the settlement is from federal relocation assistance.

(d) Permanently, if the settlement is assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, or is comparable assistance received from a state or local government or from a disaster assistance organization. Interest earned on this assistance is also excluded from resources. Any cash or in-kind items received as a settlement and excluded under this subsection are considered as available resources when not used within the allowable time periods.

(17) Insurance proceeds or other assets recovered by a Holocaust survivor as defined in WAC 388-470-0026(4).

(18) Pension funds owned by an ineligible spouse. Pension funds are defined as funds held in a(n):

(a) Individual retirement account (IRA) as described by the IRS code; or

(b) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(19) Cash payments received from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(20) SSA- or DVR-approved plans for achieving self-support (PASS) accounts, allowing blind or disabled individuals to set aside resources necessary for the achievement of the plan's goals, are excluded.

(21) Food and nutrition programs with federal involvement. This includes Washington Basic Food, school reduced and free meals and milk programs and WIC.

(22) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that code, as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(23) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children.

(24) The following are among assets that are not considered resources and as such are neither excluded nor counted:

(a) Home energy assistance/support and maintenance assistance;

(b) Retroactive in-home supportive services payments to ineligible spouses and parents; and

(c) Gifts of domestic travel tickets. For a more complete list please see POMS @ http://policy.ssa.gov/poms.nsf/lnx/0501130050.

[Statutory Authority: RCW 74.08.090 and ARRA of 2009, Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-475-0550, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0550, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0550, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0600 SSI-related medical—Definition of income. (1) Income is anything an individual receives in cash or in-kind that can be used to meet his/her needs for food, clothing, or shelter. Income can be earned or unearned.

(2) Some receipts are not income because they do not meet the definition of income above, including:

(a) Cash or in-kind assistance from federal, state, or local government programs whose purpose is to provide medical care or services;

(b) Some in-kind payments that are not food, clothing or shelter coming from nongovernmental programs whose purposes are to provide medical care or medical services;

(c) Payments for repair or replacement of an exempt resource;

(d) Refunds or rebates for money already paid;

(e) Receipts from sale of a resource;

(f) Replacement of income already received. See 20 CFR 416.1103 for a more complete list of receipts that are not income; and

(g) Receipts from extraction of exempt resources for a member of a federally recognized tribe.

(3) Earned income includes the following types of payments:

(a) Gross wages and salaries, including garnished amounts;

(b) Commissions and bonuses;

(c) Severance pay;

(d) Other special payments received because of employment;

(e) Net earnings from self-employment (WAC 388-475-0840 describes net earnings);

(f) Self-employment income of tribal members unless the income is specifically exempted by treaty;

(g) Payments for services performed in a sheltered workshop or work activities center;

(h) Royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered; or

(i) In-kind payments made in lieu of cash wages, including the value of food, clothing or shelter.

(4) Unearned income is all income that is not earned income. Some types of unearned income are:

(a) Annuities, pensions, and other periodic payments;

(b) Alimony and support payments;

(c) Dividends and interest;

(d) Royalties (except for royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered which would be earned income);

(e) Capital gains;

(f) Rents;

(g) Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient;

(h) Gifts;

(i) Inheritances;

(j) Prizes and awards; or

(k) Amounts received by tribal members from gaming revenues.

(5) Some items which may be withheld from income, but the department considers as received income are:

(a) Federal, state, or local income taxes;

(b) Health or life insurance premiums;

(c) SMI premiums;

(d) Union dues;

(e) Penalty deductions for failure to report changes;

(f) Loan payments;

(g) Garnishments;

(h) Child support payments, court ordered or voluntary (WAC 388-475-0900 has an exception for deemors);

(i) Service fees charged on interest-bearing checking accounts;

(j) Inheritance taxes;

(k) Guardianship fees if presence of a guardian is not a requirement for receiving the income.

(6) Countable income, for the purposes of this chapter, means all income that is available to the individual:

(a) If it cannot be excluded, and

(b) After deducting all allowable disregards and deductions.

[Statutory Authority: RCW 74.08.090 and ARRA of 2009 (Recovery Act), Public Law 111-5, Section 5006(b); 42 C.F.R. 435.601, EEOICPA of 2000, Public Law 106398, Sec. 1, app., Title XXXVI (Oct. 30, 2000) (section 1 adopting as Appendix H.R. 5408), Section 3646 of the Appendix. 10-15-069, § 388-475-0600, filed 7/16/10, effective 8/16/10. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0600, filed 4/7/04, effective 6/1/04.]

Chapter 388-476 WAC
SOCIAL SECURITY NUMBER

WAC

388-476-0005 Social Security number requirements.

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued. For SSN requirements for immigrants, see WAC 388-424-0009.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) If a person is unable to provide proof of application for a SSN for a newborn:

(i) The newborn can receive Basic Food with the household while effort is being made to get the SSN.

(ii) For the newborn to continue receiving Basic Food benefits; the household must provide proof of application for SSN or the SSN for the newborn, at the next recertification, or within six months following the month the baby is born, whichever is later.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The alien emergency medical program;

(d) The state-funded pregnant woman program; and

(e) Detoxification services.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.057, 74.04.510, and Title 7, 273.6 C.F.R. 10-17-101, § 388-476-0005, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090. 03-20-061, § 388-476-0005, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-476-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057 and 74.08.090. 98-16-044, § 388-476-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0530.]

Chapter 388-478 WAC
STANDARDS FOR PAYMENTS

WAC

388-478-0015 Need standards for cash assistance.
388-478-0030 Payment standards for disability lifeline and ADATSA.

WAC 388-478-0015 Need standards for cash assistance. The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard
1	$1,128
2	1,428
3	1,763
4	2,080
5	2,397
6	2,715
7	3,138
8	3,472
9	3,807
10 or more	4,142

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	$583
2	737
3	910
4	1,074
5	1,238
6	1,402
7	1,621
8	1,794
9	1,967
10 or more	2,139

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090. 11-01-121, § 388-478-0015, filed 12/20/10, effective 1/1/11; 10-04-111, § 388-478-0015, filed 2/3/10, effective 3/6/10; 08-24-070, § 388-478-0015, filed 12/1/08, effective 1/1/09; 07-24-033, § 388-478-0015, filed 11/30/07, effective 12/31/07; 07-06-066, § 388-478-0015, filed 3/5/07, effective 4/5/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-05-102, § 388-478-0015, filed 2/14/06, effective 3/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090. 05-22-077 and 05-23-012, § 388-478-0015, filed 10/31/05 and 11/4/05, effective 1/1/06; 05-01-074, § 388-478-0015, filed 12/9/04, effective 1/9/05. Statutory Authority: RCW 74.04.770, 74.04.050, 74.04.055, 74.04.057. 03-24-059, § 388-478-0015, filed 12/1/03, effective 1/1/04; 03-23-116, § 388-478-0015, filed 11/18/03, effective 12/19/03. Statutory Authority: RCW 74.08.090, 74.04.510, and 74.04.770. 02-23-029, § 388-478-0015, filed 11/12/02, effective 12/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.200. 01-11-108, § 388-478-0015, filed 5/21/01, effective 7/1/01. Statutory Authority: RCW 74.04.200. 99-04-056, § 388-478-0015, filed 1/29/99, effective 3/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0030 Payment standards for disability lifeline and ADATSA. (1) The payment standards for disability lifeline (DL) and alcohol and drug addiction treatment and support act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	$266
2	336

(2) The payment standards for DL and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$162
2	206

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090, 74.04.005, and 74.04.770. 10-24-070, § 388-478-0030, filed 11/30/10, effective 1/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0030, filed 7/31/98, effective 9/1/98.]

Chapter 388-484 WAC
TANF/SFA FIVE YEAR TIME LIMIT

WAC

388-484-0005 There is a five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance.
388-484-0006 TANF/SFA time limit extensions.
388-484-0010 How does the five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance apply to adults living in Indian country?

WAC 388-484-0005 There is a five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance. (1) **What is the sixty-month time limit?**

(a) You can receive cash assistance for temporary assistance for needy families (TANF), state family assistance (SFA), and general assistance for pregnant women (GA-S) for a lifetime limit of sixty months. The time limit applies to cash assistance provided by any combination of these programs, and whether or not it was received in consecutive months.

(b) If you receive cash assistance for part of the month, it counts as a whole month against the time limit.

(c) If you have received cash assistance from another state on or after August 1, 1997, and it was paid for with federal TANF funds, those months will count against your time limit.

(d) The time limit does not apply to diversion cash assistance, support services, food assistance or medicaid.

(2) **When did the sixty-month time limit go into effect?**

The sixty-month time limit applies to cash assistance received on or after August 1, 1997 for TANF and SFA. Although the GA-S program no longer exists, the time limit applies to GA-S cash assistance received from May 1, 1999 through July 31, 1999.

(3) **Does the time limit apply to me?**

The sixty-month time limit applies to you for any month in which you are a parent or other relative as defined in WAC 388-454-0010, or a minor parent emancipated through court order or marriage.

(4) **Do any exceptions to the time limits apply to me?**

The department does not count months of assistance towards the sixty-month time limit if you are:

(a) An adult caretaker, as described in WAC 388-454-0005 through 388-454-0010, who is not a member of the assistance unit and you are receiving cash assistance on behalf of a child;

(b) An unemancipated pregnant or parenting minor living in a department approved living arrangement as defined by WAC 388-486-0005; or

(c) An adult and you are living in Indian country, as defined under 18 U.S.C. 1151, or an Alaskan native village and you are receiving TANF, SFA, or GA-S cash assistance during a period when at least fifty percent of the adults living in Indian country or in the village were not employed. See WAC 388-484-0010.

(5) **What happens if a member of my assistance unit has received sixty months of TANF, SFA, and GA-S cash benefits?**

Once any adult or emancipated minor in the assistance unit has received sixty months of cash assistance, the entire assistance unit becomes ineligible for TANF or SFA cash assistance, unless you qualify for a hardship extension and are eligible for an extended period of cash assistance called a TANF/SFA time limit extension under WAC 388-484-0006.

(6) **What can I do if I disagree with how the department has counted my months of cash assistance?**

(a) If you disagree with how we counted your months of cash assistance, you may ask for a hearing within ninety days of the date we sent you a letter telling you how many months we are counting.

(b) You will get continued benefits (the amount you were getting before the change) if:

(i) You have used all sixty months of benefits according to our records; and

(ii) You ask for a hearing within the ten-day notice period, as described in chapter 388-458 WAC.

(c) If you get continued benefits and the administrative law judge (ALJ) agrees with our decision, you may have to pay back the continued benefits after the hearing, as described in chapter 388-410 WAC.

(7) **Does the department ever change the number of months that count against my time limit?**

We change the number of months we count in the following situations:

(a) You repay an overpayment for a month where you received benefits but were not eligible for any of the benefits you received. We subtract one month for each month that you completely repay. If you were eligible for some of the benefits you received, we still count that month against your time limit.

(b) We did not close your grant on time when the division of child support (DCS) collected money for you that was over your grant amount two months in a row, as described in WAC 388-422-0030.

(c) An ALJ decides at an administrative hearing that we should change the number of months we count.

(d) You start getting worker's compensation payments from the department of labor and industries (L&I) and your L&I benefits have been reduced by the payments we made to you.

(e) You participated in the excess real property (ERP) program in order to get assistance and we collected the funds when your property sold.

(f) Another state gave us incorrect information about the number of months you got cash assistance from them.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-24-013, § 388-484-0005, filed 11/18/10, effective 12/19/10. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-484-0005, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-010, § 388-484-0005, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.04.050, and 78.08A.340. 03-06-046, § 388-484-0005, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-484-0005, filed 5/31/02, effective 6/1/02. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0005, filed 1/26/01, effective 2/1/01. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-484-0005, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-484-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-484-0006 TANF/SFA time limit extensions. (1) **What happens after I receive sixty or more months of TANF/SFA cash assistance?**

After you receive sixty or more months of TANF/SFA cash assistance, you may qualify for additional months of cash assistance. We call these additional months of TANF/SFA cash assistance a hardship TANF/SFA time limit extension.

(2) **Who is eligible for a hardship TANF/SFA time limit extension?**

Effective February 1, 2011, you are eligible for a hardship TANF/SFA time limit extension if you are on TANF or otherwise eligible for TANF, have received sixty cumulative months of TANF and:

(a) You are approved for one of the exemptions from mandatory participation according to WAC 388-310-0350 (1)(a) through (d); or

(b) You:

(i) Have an open child welfare case with a state or tribal government and this is the first time you have had a child dependent under RCW 13.34.030 in this or another state or had a child a ward of a tribal court; or

(ii) Are working in unsubsidized employment for thirty-two hours or more per week; or

(iii) Document that you meet the family violence option criteria in WAC 388-61-001 and are participating satisfactorily in specialized activities needed to address your family violence according to a service plan developed by a person trained in family violence.

(3) **Who reviews and approves a hardship time limit extension?**

(a) Your case manager or social worker will review your case and determine whether a hardship time limit extension type will be approved.

(b) This review will not happen until after you have received at least fifty-two months of assistance but before you reach your time limit.

(c) Before you reach your time limit, the department will send you a notice that tells you whether a hardship time limit extension will be approved when your time limit expires and how to request an administrative hearing if you disagree with the decision.

(4) **Do my WorkFirst participation requirements change if I receive a hardship TANF/SFA time limit extension?**

(a) Even if you qualify for a hardship TANF/SFA time limit extension you will still be required to participate as required in your individual responsibility plan (WAC 388-310-0500). You must still meet all of the WorkFirst participation requirements listed in chapter 388-310 WAC while you receive a hardship TANF/SFA time limit extension.

(b) If you do not participate in the WorkFirst activities required by your individual responsibility plan, and you do not have a good reason under WAC 388-310-1600, the department will follow the sanction rules in WAC 388-310-1600.

(5) **Do my benefits change if I receive a hardship TANF/SFA time limit extension?**

(a) You are still a TANF/SFA recipient and your cash assistance, services, or supports will not change as long as you continue to meet all other TANF/SFA eligibility requirements.

(b) During the hardship TANF/SFA time limit extension, you must continue to meet all other TANF/SFA eligibility requirements. If you no longer meet TANF/SFA eligibility criteria during your hardship time limit extension, your benefits will end.

(6) **How long will a hardship TANF/SFA time limit extension last?**

(a) We will review your hardship TANF/SFA time limit extension and your case periodically for changes in family circumstances:

(i) If you are extended under WAC 388-484-0006 (2)(a) then we will review your extension at least every twelve months;

(ii) If you are extended under WAC 388-484-0006 (2)(b) then we will review your extension at least every six months.

(b) Your hardship TANF/SFA time limit extension may be renewed for as long as you continue to meet the criteria to qualify for a hardship time limit extension.

(c) If during the extension period we get proof that your circumstances have changed, we may review your case and determine if you continue to qualify for a hardship TANF/SFA time limit extension. When you no longer qualify for a hardship TANF/SFA time limit extension we will stop your TANF/SFA cash assistance. You will be notified of your case closing and will be given the opportunity to request an administrative hearing before your benefits will stop.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-24-013, § 388-484-0006, filed 11/18/10, effective 12/19/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-484-0006, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.340. 03-24-057, § 388-484-0006, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-484-0006, filed 5/31/02, effective 6/1/02.]

WAC 388-484-0010 How does the five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance apply to adults living in Indian country? (1) **If you are an adult living in Indian country, months of temporary assistance for needy families (TANF), state family assistance (SFA) and general assistance for pregnant women (from May 1, 1999 to July 31, 1999) do not count towards the time limit under certain circumstances.**

Months of cash assistance received do not count against the sixty-month lifetime limit while you are an adult living in Indian country or an Alaskan native village where at least fifty percent of adults are not employed.

(2) **Where must I live to qualify for the Indian country exemption to time limits?**

To qualify for this exemption to TANF time limits, you must live in "Indian country." The department uses the "Indian country" definition in federal law at 18 U.S.C. 1151. Indian country is defined as reservations, dependent Indian communities, and allotments. Dependent Indian communities must be set aside by the federal government for the use of Indians and be under federal superintendence. Near reservation areas (areas or communities adjacent or contiguous to reservations) are not considered Indian country for purposes of this exemption.

(3) **How does the department determine if at least fifty percent of adults living in Indian country are not employed?**

The department uses the most current biennial *Indian Service Population and Labor Force Estimates Report* published by the Bureau of Indian Affairs (BIA), or any successor report, as the default data source to determine if the not employed rates for areas of Indian country are at least fifty percent.

(4) **What if a tribe disagrees with the not employed rate published in the BIA Indian Service Population and Labor Force Estimates Report?**

A tribe may provide alternative data, based on similar periods to the *Indian Service Population and Labor Force Estimates Report*, to demonstrate that the not employed rate is at least fifty percent.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapters 74.08A and 74.12 RCW. 10-24-013, § 388-484-0010, filed 11/18/10, effective 12/19/10. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0010, filed 1/26/01, effective 2/1/01.]

Chapter 388-489 WAC
TRANSITIONAL FOOD ASSISTANCE

WAC

388-489-0010	How is my transitional food assistance benefit calculated?
388-489-0015	How long will my household receive transitional food assistance?
388-489-0020	Am I required to report changes in my household's circumstances while on transitional food assistance?
388-489-0022	What happens if I reapply for Basic Food while receiving transitional food assistance?
388-489-0025	Can my transitional food assistance benefits end before the end of my five-month transition period?

WAC 388-489-0010 How is my transitional food assistance benefit calculated? (1) We base your transitional food assistance benefit amount on the regular monthly benefit allotment issued to your Basic Food assistance unit for the last month your household received temporary assistance for needy families. We will not count your last temporary assistance for needy families grant payment when we calculate your transitional food assistance benefit amount. For example:

(a) If your Basic Food assistance unit's only income was temporary assistance for needy families, the transitional food assistance benefit will be the amount your household would have received if you had no income.

(b) If your Basic Food benefit was calculated using temporary assistance for needy families plus income from another source, we will count only the income from the other

source when calculating the transitional food assistance amount.

(2) We will adjust your transitional food assistance benefits if:

(a) Someone who gets transitional food assistance with you leaves your assistance unit and is found eligible to receive Basic Food in another assistance unit. We will adjust your benefits by:

(i) Reducing your assistance unit size by the number of persons who left your assistance unit; and

(ii) Removing the income and expenses clearly belonging to the persons who left your assistance unit.

(b) A change to the maximum allotment for Basic Food under WAC 388-478-0060 results in an increase in benefits for Basic Food assistance units.

(c) You got an overpayment of Basic Food benefits and we need to adjust the amount we deduct from your monthly benefits to repay the overpayment as required in WAC 388-410-0033. This includes:

(i) Starting a new monthly deduction;

(ii) Changing the amount of the monthly deduction; and

(iii) Ending the monthly deduction when the amount you owe has been paid off.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.010, and 74.08A.903. 10-23-119, § 388-489-0010, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.-010. 05-19-060, § 388-489-0010, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0015 How long will my household receive transitional food assistance? If your Basic Food assistance unit is eligible for transitional food assistance according to WAC 388-489-0005, you will receive transitional food assistance for up to five months after your household leaves temporary assistance for needy families.

(1) If you stopped getting temporary assistance for needy families from the department, you are eligible for transitional benefits beginning the month after your household received their last grant.

(2) If you stopped receiving tribal TANF benefits, you are eligible for transitional benefits:

(a) With the next monthly issuance after we update your case to show you no longer have tribal TANF income, if the tribal TANF end date is the end of the current month or the end of a prior month; or

(b) On the first of the month following the tribal TANF end date, if the tribal TANF end date is the end of a future month.

(3) If necessary, we will extend or shorten your Basic Food assistance unit's current certification period to match the five-month transition period.

(4) You may choose to end your five-month transition period early by submitting an application for regular Basic Food under WAC 388-489-0022 or by asking us to terminate your benefits.

(5) We send you a notice before the end of your five-month transition period so you can reapply for regular Basic Food benefits and continue to receive benefits without interruption as described in WAC 388-434-0010.

(6) We may terminate your transitional food assistance early for the reasons stated in WAC 388-489-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.010, and 74.08A.903. 10-13-047, § 388-489-0015, filed 6/9/10, effective 8/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0015, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0020 Am I required to report changes in my household's circumstances while on transitional food assistance? (1) If you only receive transitional food assistance, you are not required to report any changes in your household circumstances.

(2) If you receive benefits from another cash or medical assistance program, you must meet the reporting requirements for the other program as required by WAC 388-418-0005. Except for changes listed under WAC 388-489-0025, the changes you report for the other program will not affect your household's eligibility for transitional food assistance.

(3) If your household experiences a change in circumstances during your five-month transition period, and you think that you may be eligible for more food assistance, you may submit an application for the regular Basic Food program under WAC 388-489-0022. Examples of such changes include the loss of income by a person who gets transitional food assistance with you or adding a new person to your household.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.010, and 74.08A.903. 10-13-047, § 388-489-0020, filed 6/9/10, effective 8/1/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0020, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0022 What happens if I reapply for Basic Food while receiving transitional food assistance? (1) You can choose to reapply for Basic Food at any time during your TFA period. If you submit an application for Basic Food, we will:

(a) Interview you according to WAC 388-452-0005.

(b) Send you a letter if we need additional information and give you at least ten days to provide the information according to WAC 388-458-0020.

(c) Process your application within thirty days. We will keep your TFA active while your request for Basic Food is pending.

(d) Process your application according to WAC 388-434-0010 if your application was submitted in the last month of your TFA period.

(2) If you are eligible for Basic Food, we tell you the amount you will receive and allow you to choose if you want Basic Food or continue your TFA.

(3) If you choose to go back on Basic Food, we will start your new benefit amount on the first day of the month after we receive your application for Basic Food. If you already received transitional food assistance for this month and are eligible for:

(a) More assistance on Basic Food, we will pay you the additional amount.

(b) Less assistance on the Basic Food, you will have to pay back the additional amount.

(4) If you choose to go back on Basic Food and receive less assistance, we do not have to give you advance notice.

(5) If we are unable to approve your request for Basic Food, we will deny your application and continue your TFA

through the end of your transitional period, unless you become ineligible for TFA under WAC 388-489-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.010, and 74.08A.903. 10-13-047, § 388-489-0022, filed 6/9/10, effective 8/1/10.]

WAC 388-489-0025 Can my transitional food assistance benefits end before the end of my five-month transition period? Your transitional food assistance benefits will end early if:

(1) Someone who gets transitional food assistance with you applies and is approved for temporary assistance for needy families while still living in your home. You may reapply to have your eligibility for Basic Food determined;

(2) We learn that you and your household are no longer residing in the state of Washington; or

(3) **All members** of your household are ineligible to get Basic Food for any of the following reasons:

(a) Refusal to cooperate with quality assurance (WAC 388-464-0001);

(b) Transfer of property to qualify for Basic Food assistance (WAC 388-488-0010);

(c) Intentional program violation (WAC 388-466-0015 [388-446-0015] and 388-446-0020);

(d) Fleeing felon or violating a condition of probation or parole (WAC 388-442-0010);

(e) Alien status (WAC 388-424-0020);

(f) Employment and training requirements (WAC 388-444-0055 and 388-444-0075);

(g) Work requirements for able-bodied adults without dependents (WAC 388-444-0030);

(h) Student status (WAC 388-482-0005);

(i) Living in an institution where residents are not eligible for Basic Food (WAC 388-408-0040); or

(j) Deceased.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090, and 74.08A.120. 11-02-035, § 388-489-0025, filed 12/29/10, effective 2/1/11. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 09-01-049, § 388-489-0025, filed 12/10/08, effective 1/10/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0025, filed 9/16/05, effective 11/1/05.]

Chapter 388-492 WAC

WASHINGTON COMBINED APPLICATION PROJECT

WAC

388-492-0020 What are WASHCAP food benefits and what do I need to know about WASHCAP?
388-492-0030 Who can get WASHCAP?
388-492-0050 How do I apply for WASHCAP?
388-492-0070 How are my WASHCAP food benefits calculated?
388-492-0080 Where do I report changes?
388-492-0100 How is my eligibility for WASHCAP food benefits reviewed?
388-492-0110 What happens if my WASHCAP food benefits end?
388-492-0120 What happens to my WASHCAP benefits if I am disqualified?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-492-0130 What can I do if I disagree with a decision the department made about my WASHCAP benefits? [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0130, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0130, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0130, filed 10/16/01, effective 12/1/01.] Repealed by 10-23-115, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23.

WAC 388-492-0020 What are WASHCAP food benefits and what do I need to know about WASHCAP? WASHCAP means the Washington State Combined Application Project.

(1) WASHCAP is a simplified food benefits program for most single Supplemental Security Income (SSI) recipients. Unless specifically stated in this WAC chapter, WASHCAP food benefits follow all the program requirements of the Basic Food program as described under WAC 388-400-0040.

(2) The Social Security Administration (SSA) asks you if you want to get food benefits when you apply for SSI in Washington state.

(3) If you meet the requirements of WAC 388-492-0030, you will get WASHCAP food benefits unless you can choose Basic Food benefits under WAC 388-492-0040.

(4) If you are eligible for WASHCAP food benefits under WAC 388-492-0030, SSA electronically sends us the information we need to open your WASHCAP food benefits.

(5) WASHCAP food benefits begin the first month after the month you apply and are eligible for ongoing SSI.

(6) You do not have to go to your local community services office (CSO) to apply for WASHCAP.

(7) If you want Basic Food benefits before WASHCAP food benefits begin, you can apply:

(a) By contacting the customer service center (CSC) at 1-877-501-2233;

(b) Over the internet;

(c) At any community services office (CSO);

(d) At any home and community services office (HCS); or

(e) At any Social Security Administration (SSA) office.

(8) If you get Basic Food benefits, these benefits will continue:

(a) Through the end of your certification period; or

(b) Through the month before your WASHCAP food benefits start.

(9) While you get WASHCAP food benefits, you must report all changes to SSA.

(10) You do not have to report changes to your WASHCAP worker. See WAC 388-492-0080.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0020, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0020, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0020, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0020, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0030 Who can get WASHCAP? (1) You can get WASHCAP food benefits if:

(a) You are eligible to receive federal SSI benefits; and

(b) You are eighteen years of age or older; and

(c) You live alone, or SSA considers you as a single household; or

(d) You are age eighteen through twenty-one, living with your parent(s) who do not get Basic Food benefits, and you purchase food separately; or

(e) You live with others but buy and cook your food separately from them; and

(f) You do not have earned income when you apply for SSI; or

(g) You already get WASHCAP food benefits and become employed and receive earned income for less than three consecutive months and are still eligible to receive federal SSI cash benefits; or

(h) You already get WASHCAP and move to an institution for ninety days or less.

(2) You are not eligible for WASHCAP food benefits if:

(a) You live in an institution;

(b) You are under age eighteen;

(c) You live with your spouse;

(d) You are under age twenty-two and you live with your parent(s) who are getting Basic Food benefits;

(e) You begin working after you have been approved for WASHCAP and have earned income for more than three consecutive months;

(f) You live with others and do not buy and cook your food separately from them; or

(g) You are ineligible for Basic Food benefits under WAC 388-400-0040 (14)(b) and (e).

(3) We use SSA information to determine your WASHCAP eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0030, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0030, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0030, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0030, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0050 How do I apply for WASHCAP? (1) You apply for WASHCAP food benefits at the Social Security Administration (SSA) when you apply for Supplemental Security Income (SSI).

(2) If you want food benefits, your SSA worker will ask you WASHCAP food eligibility questions when you have your SSI interview.

(3) If you are eligible for WASHCAP food benefits, your benefits will start the first of the month after the month you apply and are eligible for ongoing SSI benefits.

(4) If you need food benefits in five days or less, you must apply for expedited services at:

(a) Any community services office (CSO);

(b) Any home and community services office (HCS) if you get long-term care services; or

(c) Any SSA office if you give them an application for Basic Food expedited services when you apply for SSI. SSA forwards the Basic Food application to the local CSO to process.

(5) If you want Basic Food benefits before you get SSI, you must apply at:

(a) SSA if you give them a Basic Food application when you apply for SSI;

(b) Any CSO; or

(c) Any HCS office if you get long-term care services.

(6) If you already receive SSI and want WASHCAP food benefits, you can apply at:

(a) Any SSA office;

(b) Any CSO;

(c) Any HCS office if you get long-term care services.

(7) If you get Basic Food benefits, these benefits will continue:

(a) Through the end of your certification period; or

(b) Through the month before your WASHCAP food benefits start.

(8) If your Basic Food benefits end before you are eligible for WASHCAP food benefits, you must reapply to continue these benefits.

(9) If you get Basic Food benefits and you become eligible for WASHCAP food benefits, we will automatically change your Basic Food benefits to WASHCAP food benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0050, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0050, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0050, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0050, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0070 How are my WASHCAP food benefits calculated? We calculate your food benefits as follows:

(1) We begin with your gross income.

(2) We subtract the current standard deduction for one person under WAC 388-450-0185 from your gross income to get your countable income.

(3) We figure your shelter cost based on information we receive from the Social Security Administration (SSA), unless you report a change as described under WAC 388-492-0080. If you pay:

(a) Three hundred dollars or more a month for shelter, we use three hundred seventy-nine dollars as your shelter cost; or

(b) Less than three hundred dollars for shelter, we use one hundred eighty-two dollars as your shelter cost; and

(c) We add the current standard utility allowance under WAC 388-450-0195 to determine your total shelter cost.

(4) We figure your shelter deduction by subtracting one half of your countable income from your shelter cost.

(5) We figure your net income by subtracting your shelter deduction from your countable income and rounding the resulting figure up from fifty cents and down from forty-nine cents to the nearest whole dollar.

(6) We figure your WASHCAP food benefits (allotment) by:

(a) Multiplying your net income by thirty percent and rounding up to the next whole dollar; and

(b) Subtracting the result from the maximum allotment under WAC 388-478-0060.

(c) If you are eligible for WASHCAP, you will get at least the minimum monthly benefit for Basic Food under WAC 388-412-0015.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0070, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.005,

74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 09-24-001, § 388-492-0070, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, and 74.08.090. 09-12-068, § 388-492-0070, filed 5/29/09, effective 7/1/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 08-21-106, § 388-492-0070, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-036, § 388-492-0070, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-492-0070, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-17-155, § 388-492-0070, filed 8/22/05, effective 10/1/05; 05-08-008, § 388-492-0070, filed 3/25/05, effective 4/25/05; 04-23-026, § 388-492-0070, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-492-0070, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 03-01-045, § 388-492-0070, filed 12/10/02, effective 1/10/03; 02-15-148, § 388-492-0070, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0070, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0080 Where do I report changes? (1) You report all changes to the Social Security Administration (SSA) according to their reporting requirements. Social Security reports these changes to your WASHCAP worker.

(2) SSA will not accept or report shelter costs changes to WASHCAP until SSA does its redetermination.

(3) You do not have to report any changes to your WASHCAP worker.

(4) You can choose to report the following changes to your WASHCAP worker to see if you will get more food benefits.

(a) A change in your address;

(b) An increase in your shelter costs; or

(c) An increase in your out-of-pocket medical expenses.

(5) If you or someone you authorize reports changes to DSHS, proof may be required.

(6) If you report a change that could increase the amount of your food benefits, we will not increase the benefit amount if we have asked for proof and it has not been provided.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0080, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0080, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0080, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0080, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0100 How is my eligibility for WASHCAP food benefits reviewed? (1) If the Social Security Administration (SSA) reviews your Supplemental Security Income (SSI) eligibility, they will also complete your review for WASHCAP. SSA sends us this information electronically and we will automatically extend your WASHCAP certification period.

(2) If SSA does not review your SSI eligibility, we will mail you a one-page application two months before your WASHCAP benefits end. You must complete and return this application to the WASHCAP unit or your local home and community services office (HCS).

(3) We do WASHCAP reviews by mail. If you bring your WASHCAP application to the local office, we will process the application as follows:

(a) If you get long-term care services, your local HCS office will process your application; or

(b) If you do not get long-term care services, the local office will forward your application to the WASHCAP central unit.

(4) If we get your completed application after your WASHCAP food benefits end, we will reopen your benefits back to the first of the month if:

(a) We get your application form within thirty days from the end of your certification period; and

(b) You are still eligible for WASHCAP food benefits.

(5) If we get your completed application form more than thirty days after your benefits end, your WASHCAP food benefits open the first of the next month after:

(a) You turn in your application; and

(b) SSA shows you are eligible for WASHCAP in their system.

(6) If your application is not complete, we will return it to you to complete.

(7) If you want Basic Food benefits while you are waiting for WASHCAP food benefits, you must apply for these benefits:

(a) By contacting the customer service center (CSC) at 1-877-501-2233;

(b) Over the internet;

(c) At any community services office (CSO);

(d) At any home and community services office (HCS); or

(e) At any Social Security Adminstration [Administration] (SSA) office.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0100, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0100, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0100, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0100, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0110 What happens if my WASHCAP food benefits end? (1) If your WASHCAP food benefits end because you did not have the review required under WAC 388-492-0100, you must finish the required review or apply for Basic Food benefits:

(a) By contacting the customer service center (CSC) at 1-877-501-2233;

(b) Over the internet;

(c) At any community services office (CSO);

(d) At any home and community services (HCS) office; or

(e) At any Social Security Administration (SSA) office.

(2) If your WASHCAP benefits end because you are disqualified under WAC 388-400-0040 (14)(b) or (e), you are not eligible for Basic Food benefits and:

(a) If you get medical assistance, we will send your medical assistance case to your local office;

(b) If you are a HCS client, your medical case will remain at HCS.

(3) If your WASHCAP benefits end for any other reason:

(a) We will send you an application for Basic Food benefits along with the address of your local CSO. If you are an HCS client, your case will remain at your HCS office.

(b) For the local CSO to decide if you are eligible for Basic Food benefits, you must:

(i) Finish the application process for Basic Food benefits under chapter 388-406 WAC; and

(ii) Have an interview for Basic Food benefits under WAC 388-452-0005.

(c) If you get medical assistance, we will send your medical case to the local CSO unless you are an HCS client;

(d) If your WASHCAP benefits closed because SSA ended your SSI, you will still receive the same medical benefits until we decide what medical program you are eligible for under WAC 388-418-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0110, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0110, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0110, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0110, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0120 What happens to my WASHCAP benefits if I am disqualified? (1) If you are disqualified from receiving SSI for any reason, you will not be able to get WASHCAP benefits. See WAC 388-492-0030, Who can get WASHCAP?

(2) If you are disqualified from receiving Basic Food for any reason, you will not get WASHCAP food benefits. This includes clients who:

(a) Are ineligible under WAC 388-400-0040 (14)(b) and (e) and 388-442-0010; or

(b) Did not cooperate with quality assurance as required under WAC 388-464-0001.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.08.090, 74.08A.903, and 7 C.F.R. 273.23. 10-23-115, § 388-492-0120, filed 11/17/10, effective 12/18/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0120, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0120, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0120, filed 10/16/01, effective 12/1/01.]

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

388-501-0050	Healthcare general coverage.
388-501-0055	Healthcare coverage—How the department determines coverage of services for its healthcare programs using health technology assessments.
388-501-0135	Patient review and coordination (PRC).
388-501-0200	Third-party resources.

WAC 388-501-0050 Healthcare general coverage. WAC 388-501-0050 through 388-501-0065 describe the healthcare services available to a client on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) (defined in WAC 388-538-050). For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. WAC 388-501-0070 describes noncovered services.

(1) Healthcare service categories listed in WAC 388-501-0060 do not represent a contract for healthcare services.

(2) For the provider to receive payment, the client must be eligible for the covered healthcare service on the date the healthcare service is performed or provided.

(3) Under the department's fee-for-service programs, providers must be enrolled with the department and meet the requirements of chapter 388-502 WAC to be paid for furnishing healthcare services to clients.

(4) The department pays only for the healthcare services that are:

(a) Within the scope of the client's medical program;

(b) Covered - see subsection (9) of this section;

(c) Ordered or prescribed by a healthcare provider who meets the requirements of chapter 388-502 WAC;

(d) Medically necessary as defined in WAC 388-500-0005;

(e) Submitted for authorization, when required, in accordance with WAC 388-501-0163;

(f) Approved, when required, in accordance with WAC 388-501-0165;

(g) Furnished by a provider according to chapter 388-502 WAC; and

(h) Billed in accordance with department program rules and the department's current published billing instructions and numbered memoranda.

(5) The department does not pay for any healthcare service requiring prior authorization from the department, if prior authorization was not obtained before the healthcare service was provided; unless:

(a) The client is determined to be retroactively eligible for medical assistance; and

(b) The request meets the requirements of subsection (4) of this section.

(6) The department does not reimburse clients for healthcare services purchased out-of-pocket.

(7) The department does not pay for the replacement of department-purchased equipment, devices, or supplies which have been sold, gifted, lost, broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, or misuse unless:

(a) Extenuating circumstances exist that result in a loss or destruction of department-purchased equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or

(b) Otherwise allowed under chapter 388-500 WAC.

(8) The department's refusal to pay for replacement of equipment, device, or supplies will not extend beyond the limitations stated in specific department program rules.

(9) **Covered healthcare services**

(a) Covered healthcare services are either:

(i) "Federally mandated" - means the state of Washington is required by federal regulation (42 CFR 440.210 and 220) to cover the healthcare service for medicaid clients; or

(ii) "State-option" - means the state of Washington is not federally mandated to cover the healthcare service but has chosen to do so at its own discretion.

(b) The department may limit the scope, amount, duration, and/or frequency of covered healthcare services. Limitation extensions are authorized according to WAC 388-501-0169.

(10) **Noncovered healthcare services**

(a) The department does not pay for any healthcare service:

(i) That federal or state laws or regulations prohibit the department from covering; or

(ii) Listed as noncovered in WAC 388-501-0070 or in any other program rule. The department evaluates a request for a noncovered healthcare service only if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(b) When a noncovered healthcare service is recommended during the early and periodic screening, diagnosis, and treatment (EPSDT) exam and then ordered by a provider, the department evaluates the healthcare service according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

[Statutory Authority: RCW 74.08.090. 10-07-116, § 388-501-0050, filed 3/22/10, effective 4/22/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0050, filed 11/18/09, effective 12/19/09; 06-24-036, § 388-501-0050, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 01-12-070, § 388-501-0050, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0050, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0055 Healthcare coverage—How the department determines coverage of services for its healthcare programs using health technology assessments. (1) The department uses health technology assessments in determining whether a new technology, new indication, or existing technology approved by the Food and Drug Administration (FDA) is a covered service under department healthcare programs. The department only uses health technology assessments when coverage is not mandated by federal or state law. A health technology assessment may be conducted by or on behalf of:

(a) The department; or

(b) The health technology assessment clinical committee (HTACC) according to RCW 70.14.080 through 70.14.140.

(2) The department reviews available evidence relevant to a medical or dental service or healthcare-related equipment and uses a technology evaluation matrix, in order to:

(a) Determine its efficacy, effectiveness, and safety;

(b) Determine its impact on health outcomes;

(c) Identify indications for use;

(d) Identify potential for misuse or abuse; and

(e) Compare to alternative technologies to assess benefit vs. harm and cost effectiveness.

(3) The department may determine the technology, device, or technology-related supply is:

(a) Covered (See WAC 388-501-0060 for the scope of coverage for department medical assistance programs.);

(b) Covered with authorization (See WAC 388-501-0165 for the process on how authorization is determined.);

(c) Covered with limitations (See WAC 388-501-0169 for how limitations can be extended.); or

(d) Noncovered (See WAC 388-501-0070 for the services determined to be noncovered.).

(4) The department may periodically review existing technologies, devices, or technology-related supplies and reassign authorization requirements as necessary according to the same provisions as outlined above for new technologies, devices, or technology-related supplies.

(5) The department evaluates the evidence and criteria presented by HTACC to determine whether a service is covered in accordance with WAC 388-501-0050 (9) and (10) and this section.

[Statutory Authority: RCW 74.08.090. 10-07-116, § 388-501-0055, filed 3/22/10, effective 4/22/10. Statutory Authority: RCW 74.08.090 and 70.14.090. 09-17-004, § 388-501-0055, filed 8/6/09, effective 9/6/09.]

WAC 388-501-0135 Patient review and coordination (PRC). (1) **Patient review and coordination (PRC)** program, formerly known as the patient review and restriction (PRR) program, coordinates care and ensures that clients selected for enrollment in PRC use services appropriately and in accordance with department rules and policies.

(a) PRC applies to medical assistance fee-for-service and managed care clients. PRC does not apply to clients eligible for the family planning only program.

(b) PRC is authorized under federal medicaid law by 42 USC 1396n (a)(2) and 42 CFR 431.54.

(2) **Definitions.** The following definitions apply to this section only:

"Appropriate use"—Use of healthcare services that are adapted to or appropriate for a client's healthcare needs.

"Assigned provider"—A department-enrolled healthcare provider or one participating with a department contracted managed care organization (MCO) who agrees to be assigned as a primary provider and coordinator of services for a fee-for-service or managed care client in the PRC program. Assigned providers can include a primary care provider (PCP), a pharmacy, a controlled substances prescriber, and a hospital for nonemergent hospital services.

"At-risk"—A term used to describe one or more of the following:

(a) A client with a medical history of:

• Indications of forging or altering prescriptions;

• Seeking and/or obtaining healthcare services at a frequency or amount that is not medically necessary;

• Potential life-threatening events or life-threatening conditions that required or may require medical intervention.

(b) Behaviors or practices that could jeopardize a client's medical treatment or health including, but not limited to:

• Referrals from social services personnel about inappropriate behaviors or practices that places the client at risk;

• Noncompliance with treatment;

• Paying cash for controlled substances;

• Positive urine drug screen for illicit street drugs or nonprescribed controlled substances; or

• Unauthorized use of a client's services card or for an unauthorized purpose.

"Care management"—Services provided to clients with multiple health, behavioral, and social needs in order to improve care coordination, client education, and client self-management skills.

"Client"—A person enrolled in a department healthcare program and receiving service from fee-for-service provider(s) or a managed care organization (MCO), contracted with the department.

"Conflicting"—Drugs and/or healthcare services that are incompatible and/or unsuitable for use together because of undesirable chemical or physiological effects.

"Contraindicated"—To indicate or show a medical treatment or procedure is inadvisable or not recommended or warranted.

"Controlled substances prescriber"—Any of the following healthcare professionals who, within their scope of professional practice, are licensed to prescribe and administer controlled substances (see chapter 69.50 RCW, uniform controlled substance act) for a legitimate medical purpose:

- A physician under chapter 18.71 RCW;
- A physician assistant under chapter 18.71A RCW;
- An osteopathic physician under chapter 18.57 RCW;
- An osteopathic physician assistant under chapter 18.57A RCW; and
- An advanced registered nurse practitioner under chapter 18.79 RCW.

"Duplicative"—Applies to the use of the same or similar drugs and healthcare services without due justification. Example: A client receives healthcare services from two or more providers for the same or similar condition(s) in an overlapping time frame, or the client receives two or more similarly acting drugs in an overlapping time frame, which could result in a harmful drug interaction or an adverse reaction.

"Just cause"—A legitimate reason to justify the action taken, including but not limited to, protecting the health and safety of the client.

"Managed care organization" or **"MCO"**—An organization having a certificate of authority or certificate of registration from the office of insurance commissioner, that contracts with the department under a comprehensive risk contract to provide prepaid healthcare services to eligible medical assistance clients under the department's managed care programs.

"Managed care client"—A medical assistance client enrolled in, and receiving healthcare services from, a department-contracted managed care organization (MCO).

"Primary care provider" or **"PCP"**—A person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides healthcare services to a client, initiates referrals for specialty and ancillary care, and maintains the client's continuity of care.

(3) **Clients selected for PRC review.** The department or MCO selects a client for PRC review when either or both of the following occur:

(a) A utilization review report indicates the client has not utilized healthcare services appropriately; or

(b) Medical providers, social service agencies, or other concerned parties have provided direct referrals to the department or MCO.

(4) **When a fee-for-service client is selected for PRC review** the prior authorization process as defined in chapter 388-530 WAC may be required:

(a) Prior to or during a PRC review; or

(b) When currently in the PRC program.

(5) **Review for placement in the PRC program.** When the department or MCO selects a client for PRC review, the department or MCO staff, with clinical oversight, reviews a client's medical and/or billing history to determine if the client has utilized healthcare services at a frequency or amount that is not medically necessary (42 CFR 431.54(e)).

(6) **Utilization guidelines for PRC placement.** Department or MCO staff use the following utilization guidelines to determine PRC placement. A client may be placed in the PRC program when medical and/or billing histories document any of the following:

(a) Any two or more of the following conditions occurred in a period of ninety consecutive calendar days in the previous twelve months. The client:

(i) Received services from four or more different providers, including physicians, advanced registered nurse practitioners (ARNPs), and physician assistants (PAs);

(ii) Had prescriptions filled by four or more different pharmacies;

(iii) Received ten or more prescriptions;

(iv) Had prescriptions written by four or more different prescribers;

(v) Received similar services from two or more providers in the same day; or

(vi) Had ten or more office visits.

(b) Any one of the following occurred within a period of ninety consecutive calendar days in the previous twelve months. The client:

(i) Made two or more emergency department visits;

(ii) Has a medical history that indicates "at-risk" utilization patterns;

(iii) Made repeated and documented efforts to seek healthcare services that are not medically necessary; or

(iv) Has been counseled at least once by a health care provider, or a department or MCO staff member, with clinical oversight, about the appropriate use of healthcare services.

(c) The client received prescriptions for controlled substances from two or more different prescribers in any one month in a period of ninety consecutive days in the previous twelve months.

(d) The client's medical and/or billing history demonstrates a pattern of the following at any time in the previous twelve months:

(i) The client has a history of using healthcare services in a manner that is duplicative, excessive, or contraindicated; or

(ii) The client has a history of receiving conflicting healthcare services, drugs, or supplies that are not within acceptable medical practice.

(7) **PRC review results.** As a result of the PRC review, the department or MCO staff may take any of the following steps:

(a) Determine that no action is needed and close the client's file;

(b) Send the client and, if applicable, the client's authorized representative, a letter of concern with information on specific findings and notice of potential placement in the PRC program; or

(c) Determine that the utilization guidelines for PRC placement establish that the client has utilized healthcare services at an amount or frequency that is not medically necessary, in which case the department or MCO will take one or more of the following actions:

(i) Refer the client for education on appropriate use of healthcare services;

(ii) Refer the client to other support services or agencies; or

(iii) Place the client into the PRC program for an initial placement period of twenty-four months.

(8) **Initial placement in the PRC program.** When a client is initially placed in the PRC program:

(a) The department or MCO places the client for twenty-four months with one or more of the following types of healthcare providers:

(i) Primary care provider (PCP) (as defined in subsection (2) of this section);

(ii) Pharmacy;

(iii) Controlled substances prescriber;

(iv) Hospital (for nonemergent hospital services); or

(v) Another qualified provider type, as determined by department or MCO program staff on a case-by-case basis.

(b) The managed care client will remain in the same MCO for no less than twelve months unless:

(i) The client moves to a residence outside the MCO's service area and the MCO is not available in the new location; or

(ii) The client's assigned provider no longer participates with the MCO and is available in another MCO, and the client wishes to remain with the current provider.

(c) A managed care client placed in the PRC program must remain in the PRC program for the initial twenty-four month period regardless of whether the client changes MCOs or becomes a fee-for-service client.

(d) A care management program may be offered to a client.

(9) **Notifying the client about placement in the PRC program.** When the client is initially placed in the PRC program, the department or the MCO sends the client and, if applicable, the client's authorized representative, a written notice containing at least the following components:

(a) Informs the client of the reason for the PRC program placement;

(b) Directs the client to respond to the department or MCO within ten business days of the date of the written notice about taking the following actions:

(i) Select providers, subject to department or MCO approval;

(ii) Submit additional healthcare information, justifying the client's use of healthcare services; or

(iii) Request assistance, if needed, from the department or MCO program staff.

(c) Informs the client of hearing or appeal rights (see subsection (14) of this section).

(d) Informs the client that if a response is not received within ten days of the date of the notice, the client will be assigned a provider(s) by the department or MCO.

(10) **Selection and role of assigned provider.** A client may be afforded a limited choice of providers.

(a) The following providers are not available:

(i) A provider who is being reviewed by the department or licensing authority regarding quality of care;

(ii) A provider who has been suspended or disqualified from participating as a department-enrolled or MCO-contracted provider; or

(iii) A provider whose business license is suspended or revoked by the licensing authority.

(b) For a client placed in the PRC program, the assigned:

(i) Provider(s) must be located in the client's local geographic area, in the client's selected MCO, and/or be reasonably accessible to the client.

(ii) Primary care provider (PCP) supervises and coordinates healthcare services for the client, including continuity of care and referrals to specialists when necessary. The PCP must be one of the following:

(A) A physician who meets the criteria as defined in chapter 388-502 WAC;

(B) An advanced registered nurse practitioner (ARNP) who meets the criteria as defined in chapter 388-502 WAC; or

(C) A licensed physician assistant (PA), practicing with a supervising physician.

(iii) Controlled substances prescriber prescribes all controlled substances for the client.

(iv) Pharmacy fills all prescriptions for the client.

(v) Hospital provides all nonemergent hospital services.

(c) A client placed in the PRC program cannot change assigned providers for twelve months after the assignments are made, unless:

(i) The client moves to a residence outside the provider's geographic area;

(ii) The provider moves out of the client's local geographic area and is no longer reasonably accessible to the client;

(iii) The provider refuses to continue to serve the client;

(iv) The client did not select the provider. The client may request to change an assigned provider once within thirty calendar days of the initial assignment;

(v) The client's assigned provider no longer participates with the MCO. In this case, the client may select a new provider from the list of available providers in the MCO or follow the assigned provider to the new MCO.

(d) When an assigned prescribing provider no longer contracts with the department:

(i) All prescriptions from the provider are invalid thirty calendar days following the date the contract ends; and

(ii) All prescriptions from the provider are subject to applicable prescription drugs (outpatient) rules in chapter 388-530 WAC or appropriate MCO rules.

(iii) The client must choose or be assigned another provider according to the requirements in this section.

(11) **PRC placement periods.** The length of time for a client's PRC placement includes:

(a) The initial period of PRC placement, which is a minimum of twenty-four consecutive months.

(b) The second period of PRC placement, which is an additional thirty-six consecutive months.

(c) The third period and each subsequent period of PRC placement, which is an additional seventy-two months.

(12) **Department review of a PRC placement period.** The department or MCO reviews a client's use of healthcare services prior to the end of each PRC placement period described in subsection (11) of this section using the utilization guidelines in subsection (6) of this section.

(a) The department or MCO assigns the next PRC placement period if the utilization guidelines for PRC placement in subsection (6) apply to the client.

(b) When the department or MCO assigns a subsequent PRC placement period, the department or MCO sends the client and, if applicable, the client's authorized representative, a written notice informing the client:

(i) The reason for the subsequent PRC program placement;

(ii) The length of the subsequent PRC placement;

(iii) That the current providers assigned to the client continue to be assigned to the client during the subsequent PRC placement period;

(iv) That all PRC program rules continue to apply; and

(v) Of hearing or appeal rights (see subsection (14) of this section);

(vi) Of the rules that support the decision.

(c) The department may remove a client from PRC placement if the client:

(i) Successfully completes a treatment program that is provided by a chemical dependency service provider certified by the department under chapter 388-805 WAC;

(ii) Submits documentation of completion of the approved treatment program to the department; and

(iii) Maintains appropriate use of healthcare services within the utilization guidelines described in subsection (6) for six months after the date the treatment ends.

(d) The department or MCO determines the appropriate placement period for a client who has been placed back into the program.

(e) A client will remain placed in the PRC program regardless of change in eligibility program type or change in address.

(13) **Client financial responsibility.** A client placed in the PRC program may be billed by a provider and held financially responsible for healthcare services when the client obtains nonemergent services and the provider who renders the services is not assigned or referred under the PRC program.

(14) **Right to hearing or appeal.**

(a) A fee-for-service client who believes the department has taken an invalid action pursuant to this section may request a hearing.

(b) A managed care client who believes the MCO has taken an invalid action pursuant to this section or chapter 388-538 WAC must exhaust the MCO's internal appeal process set forth in WAC 388-538-110 prior to requesting a hearing. Managed care clients can not change MCOs until the appeal or hearing is resolved and there is a final ruling.

(c) A client must request the hearing or appeal within ninety calendar days after the client receives the written notice of placement in the PRC program.

(d) The department conducts a hearing according to chapter 388-02 WAC. Definitions for the terms "hearing," "initial order," and "final order" used in this subsection are found in WAC 388-02-0010.

(e) A client who requests a hearing or appeal within ten calendar days from the date of the written notice of an initial PRC placement period under subsection (11)(a) of this section will not be placed in the PRC program until the date an initial order is issued that supports the client's placement in the PRC program or otherwise ordered by an administrative law judge (ALJ).

(f) A client who requests a hearing or appeal more than ten calendar days from the date of the written notice under subsection (9) of this section will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(g) A client who requests a hearing or appeal within ninety days from the date of receiving the written notice under subsection (9) of this section and who has already been assigned providers will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(h) An administrative law judge (ALJ) may rule that the client be placed in the PRC program prior to the date the record is closed and prior to the date the initial order is issued based on a showing of just cause.

(i) The client who requests a hearing challenging placement into the PRC program has the burden of proving the department's or MCO's action was invalid. For standard of proof, see WAC 388-02-0485.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-501-0135, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 431.51, 431.54(e) and 456.1; 42 U.S.C. 1396n. 08-05-010, § 388-501-0135, filed 2/7/08, effective 3/9/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.04.055, and 42 C.F.R. 431.54. 06-14-062, § 388-501-0135, filed 6/30/06, effective 7/31/06. Statutory Authority: RCW 74.08.090, 74.04.055, and 42 C.F.R. Subpart B 431.51, 431.54 (e) and (3), and 456.1. 04-01-099, § 388-501-0135, filed 12/16/03, effective 1/16/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-501-0135, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057 and 74.08.090. 98-16-044, § 388-501-0135, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-03-038, § 388-501-0135, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0135, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-100.]

WAC 388-501-0200 Third-party resources. (1) The department requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) The department pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the EPSDT program.

(3) The department pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to the department documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill the department or the client for a covered service when a third party pays a provider the same amount as or more than the department rate.

(5) When the provider receives payment from the third party after receiving reimbursement from the department, the provider must refund to the department the amount of the:

(a) Third-party payment when the payment is less than the department's maximum allowable rate; or

(b) The department payment when the third-party payment is equal to or greater than the department's maximum allowable rate.

(6) The department is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills the department, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) The department considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, the department is responsible for providing medical services as described under WAC 388-501-0100.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-501-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.08.090. 00-11-141, § 388-501-0200, filed 5/23/00, effective 6/23/00;00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

Chapter 388-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—PROVIDERS

WAC

388-502-0100 General conditions of payment.
388-502-0120 Payment for healthcare services provided outside the state of Washington.
388-502-0150 Time limits for providers to bill the department.
388-502-0160 Billing a client.
388-502-0210 Statistical data-provider reports.
388-502-0220 Administrative appeal contractor/provider rate reimbursement.

WAC 388-502-0100 General conditions of payment.

(1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

(d) The provider bills within the time frame set in WAC 388-502-0150;

(e) The provider bills according to department rules and billing instructions; and

(f) The provider follows third-party payment procedures.

(2) The department is the payer of last resort, unless the other payer is:

(a) An Indian health service;

(b) A crime victims program through the department of labor and industries; or

(c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The department does not reimburse providers for medical services identified by the department as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:

(a) Copayments (co-pays) (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(b) Deductibles (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(c) Emergency medical expense requirements (EMER); and

(d) Spenddown (see WAC 388-519-0110).

(4) The provider must accept medicare assignment for claims involving clients eligible for both medicare and medical assistance before the department makes any payment.

(5) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

(6) The department may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

(a) The department considered the person eligible at the time of service;

(b) The service was not otherwise paid for; and

(c) The provider submits a request for payment to the department.

(7) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

(8) Information about medical care for jail inmates is found in RCW 70.48.130.

(9) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0100, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-502-0100, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0120 Payment for healthcare services provided outside the state of Washington. (1) The department pays for healthcare services provided outside the state of Washington only when the service meets the provisions set forth in WAC 388-501-0180, 388-501-0182, 388-501-0184, and specific program WAC.

(2) With the exception of hospital services and nursing facilities, the department pays the provider of service in designated bordering cities as if the care was provided within the state of Washington (see WAC 388-501-0175).

(3) With the exception of designated bordering cities, the department does not pay for healthcare services provided to clients in medical care services (MCS) programs outside the state of Washington (see WAC 388-556-0500).

(4) With the exception of hospital services (see subsection (5) of this section), the department pays for healthcare services provided outside the state of Washington at the lower of:

(a) The billed amount; or

(b) The rate established by the Washington state medical assistance programs.

(5) The department pays for hospital services provided in designated bordering cities and outside the state of Washington in accordance with the provisions of WAC 388-550-3900, 388-550-4000, 388-550-4800 and 388-550-6700.

(6) The department pays nursing facilities located outside the state of Washington when approved by the aging and disability services administration (ADSA) at the lower of the billed amount or the adjusted statewide average reimbursement rate for in-state nursing facility care, only in the following limited circumstances:

(a) Emergency situations; or

(b) When the client intends to return to Washington state and the out-of-state stay is for:

(i) Thirty days or less; or

(ii) More than thirty days if approved by ADSA.

(7) To receive payment from the department, an out-of-state provider must:

(a) Have a signed agreement with the department;

(b) Meet the functionally equivalent licensing requirements of the state or province in which care is rendered;

(c) Meet the conditions in WAC 388-502-0100 and 388-502-0150;

(d) Satisfy all medicaid conditions of participation;

(e) Accept the department's payment as payment in full according to 42 CFR 447.15; and

(f) If a Canadian provider, bill at the U.S. exchange rate in effect at the time the service was provided.

(8) For covered services for eligible clients, the department reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX medicaid program.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0120, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.-057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-502-0120, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-502-0120, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

WAC 388-502-0150 Time limits for providers to bill the department. Providers must bill the department for covered services provided to eligible clients as follows:

(1) The department requires providers to submit initial claims and adjust prior claims in a timely manner. The department has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims and claims for major trauma services, see subsections (7) and (8) of this section;

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section; and

(d) For resubmitting claims for major trauma services, see subsection (11) of this section.

(2) The provider must submit claims to the department as described in the department's current published billing instructions.

(3) Providers must submit the initial claim to the department and have a transaction control number (TCN) assigned by the department within three hundred sixty-five calendar days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders the department to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) The department may grant exceptions to the time limit of three hundred sixty-five calendar days for initial claims when billing delays are caused by either of the following:

(a) The department's certification of a client for a retroactive period; or

(b) The provider proves to the department's satisfaction that there are other extenuating circumstances.

(5) The department requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to the department's billing limits.

(6) When a client is covered by both medicare and medicaid, the provider must bill medicare for the service before billing the initial claim to the department. If medicare:

(a) Pays the claim the provider must bill the department within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, the department requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) The following applies to claims with a date of service or admission before July 1, 2009:

(a) Within thirty-six months of the date the service was provided to the client, a provider may resubmit, modify, or adjust any claim, other than a prescription drug claim or a claim for major trauma services, with a timely TCN. This applies to any claim, other than a prescription drug claim or a claim for major trauma services, that met the time limits for an initial claim, whether paid or denied. The department does

not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(b) After thirty-six months from the date the service was provided to the client, a provider cannot refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(8) The following applies to claims with a date of service or admission on or after July 1, 2009:

(a) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services.

(b) After twenty-four months from the date the service was provided to the client, the department does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the department by a negotiable financial instrument, such as a bank check.

(9) The department allows providers to resubmit, modify, or adjust any prescription drug claim with a timely TCN within fifteen months of the date the service was provided to the client. After fifteen months, the department does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) The department allows a provider of trauma care services to resubmit, modify, or adjust, within three hundred and sixty-five calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 388-531-2000 (for physician claims) or WAC 388-550-5450 (for hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).

(a) No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after three hundred sixty-five calendar days from the date of service.

(b) Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to the provisions of this section.

(12) The three hundred sixty-five-day period described in subsection (11) of this section does not apply to overpayments from the TCF that a trauma care provider must refund to the department. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by the department.

(13) If a provider fails to bill a claim according to the requirements of this section and the department denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.-057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-502-0150, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0160 Billing a client. (1) The purpose of this section is to specify the limited circumstances in which:

(a) Fee-for-service or managed care clients can choose to self-pay for medical assistance services; and

(b) Providers (as defined in WAC 388-500-0005) have the authority to bill fee-for-service or managed care clients for medical assistance services furnished to those clients.

(2) The provider is responsible for:

(a) Verifying whether the client is eligible to receive medical assistance services on the date the services are provided;

(b) Verifying whether the client is enrolled with a department-contracted managed care organization (MCO);

(c) Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC 388-501-0050 (4)(a) and 388-501-0065);

(d) Informing the client of those limitations;

(e) Exhausting all applicable department or department-contracted MCO processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by the department or department-contracted MCO for medical assistance services furnished to clients. See 42 CFR § 447.15.

(4) A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in department's rules, the department's fee-for-service billing instructions, and the requirements for billing the department-contracted MCO in which the client is enrolled, and until the provider has then fully informed the client of his or her covered options. A provider must not bill a client for:

(a) Any services for which the provider failed to satisfy the conditions of payment described in department's rules, the department's fee-for-service billing instructions, and the requirements for billing the department-contracted MCO in which the client is enrolled.

(b) A covered service even if the provider has not received payment from the department or the client's MCO.

(c) A covered service when the department denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC 388-501-0165 (7)(c)(i).

(5) If the requirements of this section are satisfied, then a provider may bill a fee-for-service or a managed care client for a covered service, defined in WAC 388-501-0050(9), or a noncovered service, defined in WAC 388-501-0050(10) and 388-501-0070. The client and provider must sign and date the DSHS form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. DSHS form 13-879, including translated versions, is available to download at http://www1.dshs.wa.gov/msa/forms/eforms.html. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the department or department-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC 388-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the department or department-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 388-501-0160 when the department denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with WAC 388-526-2610 to appeal the department's denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable department or department-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding department denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the department or the client's department-contracted MCO and the ETR process as described in WAC 388-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the department or the client's department-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 388-501-0160;

(iii) Covered by the department or the client's department-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the department denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 388-501-0169); or

(iv) Covered by the department or the client's department-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the department or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it;

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the department for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

(6) There are limited circumstances in which a provider may bill a client without executing DSHS form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section. The following are those circumstances:

(a) The client, the client's legal guardian, or the client's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 388-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

(b) The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:

(i) Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and

(ii) Give a copy of the document to the client and maintain the original for six years from the date of service, for department review upon request.

(c) The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the department). See subsection (7) of this section for billing a medically needy client for spenddown liability;

(d) The client is under the department's or a department-contracted MCO's patient review and coordination (PRC) program (WAC 388-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program;

(e) The client is a dual-eligible client with medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC 388-530-7700 (2)(a)(iii) are met;

(f) The services provided to a TAKE CHARGE or family planning only client are not within the scope of the client's benefit package;

(g) The services were noncovered ambulance services (see WAC 388-546-0250(2));

(h) A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the department after being informed by the provider that he or she is not contracted with the department and that the services

offered will not be paid by the client's healthcare program; and

(i) A department-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO, i.e., a nonparticipating provider.

(7) Under chapter 388-519 WAC, an individual who has applied for medical assistance is required to spend down excess income on healthcare expenses to become eligible for coverage under the medically needy program. An individual must incur healthcare expenses greater than or equal to the amount that he or she must spend down. The provider is prohibited from billing the individual for any amount in excess of the spenddown liability assigned to the bill.

(8) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an individual and then bill the department for the covered service that had been furnished. In these situations, the individual becomes eligible for a covered service that had already been furnished. Providers must then accept as payment in full the amount paid by the department or managed care organization for medical assistance services furnished to clients. These situations are as follows:

(a) The individual was not receiving medical assistance on the day the service was furnished. The individual applies for medical assistance later in the same month in which the service was provided and the department makes the individual eligible for medical assistance from the first day of that month;

(b) The client receives a delayed certification for medical assistance as defined in WAC 388-500-0005; or

(c) The client receives a certification for medical assistance for a retroactive period according to 42 CFR § 435.914 (a) and defined in WAC 388-500-0005.

(9) Regardless of any written, signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from a client, anyone on the client's behalf, or the department for:

(a) Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, cancelled, or late appointments;

(c) Shipping and/or postage charges;

(d) "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0160, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.15. 10-10-022, § 388-502-0160, filed 4/26/10, effective 5/27/10. Statutory Authority: RCW 74.08.090, 74.09.055, 2001 c 7, Part II. 02-12-070, § 388-502-0160, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.08.090. 01-21-023, § 388-502-0160, filed 10/8/01, effective 11/8/01; 01-05-100, § 388-502-0160, filed 2/20/01, effective 3/23/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0210 Statistical data-provider reports. (1) At the request of the department, all providers enrolled with department programs must submit full reports, as specified by the department, of goods and services furnished to eligible medical assistance clients. The department furnishes the provider with a standardized format to report these data.

(2) The department analyzes the data collected from the providers' reports to secure statistics on costs of goods and services furnished and makes a report of the analysis available to the department's advisory committee, the state welfare medical care committee, representative organizations of provider groups enrolled with the department, and any other interested organizations or individuals.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0210, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.035. 00-15-049, § 388-502-0210, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

WAC 388-502-0220 Administrative appeal contractor/provider rate reimbursement. (1) Any enrolled contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the department reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with the department.

(a) The appeal must include all of the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for the department to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, the department may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, the department may do one or both of the following:

(i) Request additional information; and/or

(ii) Conduct an audit of the documentation provided.

(d) The department issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When the department requests additional information, the contractor/provider has forty-five calendar days from the date of the department's request to submit the additional information.

(ii) The department issues a decision within thirty calendar days of receipt of the completed information.

(e) The department may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from the department. The department does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) The department may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that the department grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with the department. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to the department within thirty calendar days after the contractor/provider receives the rate review decision. The department does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) The department conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(4) The department considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-502-0220, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

Chapter 388-527 WAC
ESTATE RECOVERY AND PRE DEATH LIENS

WAC

388-527-2730 Definitions.
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WAC 388-527-2730 Definitions. The following definitions apply to this chapter:

"Contract health service delivery area (CHSDA)" means the geographic area within which contract health services will be made available by the Indian health service to members of an identified Indian community who reside in the area as identified in 42 C.F.R. Sec. 136.21(d) and 136.22.

"Domestic partner" means an adult who meets the requirements for a valid registered domestic partnership as established by RCW 26.60.030 and who has been issued a certificate of state registered domestic partnership by the Washington secretary of state. When the terms "domestic partner" or "domestic partnership" are used in this chapter, they mean "state registered domestic partner" or "state registered domestic partnership."

"Estate" means all property and any other assets that pass upon the client's death under the client's will or by intestate succession pursuant to chapter 11.04 RCW or under chapter 11.62 RCW. The value of the estate will be reduced by any valid liability against the decedent's property at the time of death. An estate also includes:

(1) For a client who died after June 30, 1995 and before July 27, 1997, nonprobate assets as defined by RCW 11.02.005, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997 and before September 14, 2006, nonprobate assets as defined by RCW 11.02.005.

(3) For a client who died on or after September 14, 2006, nonprobate assets as defined by RCW 11.02.005 and any life estate interest held by the recipient immediately before death.

"Heir" means the decedent's surviving spouse and children (natural and adopted); or those persons who are entitled to inherit the decedent's property under a will properly executed under RCW 11.12.020 and accepted by the probate court as a valid will.

"Joint tenancy" means ownership of property held under circumstances that entitle one or more owners to the whole of the property on the death of the other owner(s), including, but not limited to, joint tenancy with right of survivorship.

"Life estate" means an ownership interest in a property only during the lifetime of the person(s) owning the life estate. In some cases, the ownership interest lasts only until the occurrence of some specific event, such as remarriage of the life estate owner. A life estate owner may not have the legal title or deed to the property, but may have rights to possession, use, income and/or selling their life estate interest in the property.

"Lis pendens" means a notice filed in public records warning that title to certain real property is in litigation and the outcome of the litigation may affect the title.

"Long-term care services" means, for the purposes of this chapter only, the services administered directly or through contract by the department of social and health services for clients of the home and community services division and division of developmental disabilities including, but not limited to, nursing facility care and home and community services.

"Medicaid" means the state and federally funded program that provides medical services under Title XIX of the Federal Social Security Act.

"Medical assistance" means medicaid services funded under Title XIX or state-funded medical services.

"Medicare savings programs" means the programs described in WAC 388-517-0300 that help a client pay some of the costs that medicare does not cover.

"Property": Examples include, but are not limited to, personal property, real property, title property, and trust property as described below:

(1) **"Personal property"** means any property that is not classified as real, title, or trust property in the definitions provided here;

(2) **"Real property"** means land and anything growing on, attached to, or erected thereon;

(3) **"Title property"** means, for the purposes of this chapter only, property with a title such as motor homes, mobile homes, boats, motorcycles, and vehicles.

(4) **"Trust property"** means any type of property interest titled in, or held by, a trustee for the benefit of another person or entity.

"State-only funded long-term care" means the long-term care services that are financed with state funds only.

"Qualified long-term care insurance partnership" means an agreement between the centers for medicare and medicaid services (CMS), the Washington state insurance commission which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(C)(iii) of the act.

[Statutory Authority: RCW 74.08.090 and 2008 Medicare Improvements for Patient and Providers Act (which amended Section 1917 (b)(1)(B)(ii) of the Social Security Act); Deficit Reduction Act of 2005 (incorporating language regarding LTC partnership agreements). 10-08-110, § 388-527-2730, filed 4/7/10, effective 5/8/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and chapter 26.60 RCW. 09-07-038, § 388-527-2730, filed 3/10/09, effective 4/10/09. Statutory Authority: 2005 c 292, RCW 43.20B.-080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2730, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2730, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2730, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2730, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2733 Estate liability. (1) The client's estate is not liable for services provided before July 26, 1987.

(2) The client's estate is not liable when the client died before July 1, 1994 and on the date of death there was:

(a) A surviving spouse; or

(b) A surviving child who was either:

(i) Under twenty-one years of age; or

(ii) Blind or disabled as defined under chapter 388-511 WAC.

(3) The estate of a frail elder or vulnerable adult under RCW 74.34.005 is not liable for the cost of adult protective services (APS) financed with state funds only.

(4) On or before December 31, 2009, the client's estate is not liable for amounts paid for medicare premiums and other cost-sharing expenses incurred on behalf of a client who is eligible only for the medicare savings programs (MSP), and not otherwise medicaid eligible.

(5) On or after January 1, 2010, the client's estate is not liable for amounts paid for medical assistance cost-sharing for benefits for clients who received coverage under a MSP only or for clients who receive coverage under a medicare savings program and medicaid as described in 42 USC 1396a (a)(10)(E).

[Statutory Authority: RCW 74.08.090 and 2008 Medicare Improvements for Patient and Providers Act (which amended Section 1917 (b)(1)(B)(ii) of the Social Security Act); Deficit Reduction Act of 2005 (incorporating language regarding LTC partnership agreements). 10-08-110, § 388-527-2733, filed 4/7/10, effective 5/8/10. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2733, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2733, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2737 Deferring recovery. (1) For a client who died after June 30, 1994, the department defers recovery from the estate until:

(a) The death of the surviving spouse, if any; and

(b) There is no surviving child who is:

(i) Twenty years of age or younger; or

(ii) Blind or disabled at the time of the client's death, as defined under WAC 388-475-0050.

[Statutory Authority: RCW 74.08.090 and 2008 Medicare Improvements for Patient and Providers Act (which amended Section 1917 (b)(1)(B)(ii) of the Social Security Act); Deficit Reduction Act of 2005 (incorporating language regarding LTC partnership agreements). 10-08-110, § 388-527-2737, filed 4/7/10, effective 5/8/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and chapter 26.60 RCW. 09-07-038, § 388-527-2737, filed 3/10/09, effective 4/10/09. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2737, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.20B.-080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2737, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2742 Services subject to recovery. The department considers the medical services the client received and the dates when the services were provided to the client, in order to determine whether the client's estate is liable for the cost of medical services provided. Subsection (1) of this section covers liability for medicaid services, subsection (2) covers liability for state-only funded long-term care services, and subsection (3) covers liability for all other state-funded services. An estate can be liable under any of these subsections.

(1) The client's estate is liable for:

(a) All medicaid services provided from July 26, 1987 through June 30, 1994;

(b) The following medicaid services provided after June 30, 1994 and before July 1, 1995:

(i) Nursing facility services;

(ii) Home and community-based services; and

(iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following medicaid services provided after June 30, 1995 and before June 1, 2004:

(i) Nursing facility services;

(ii) Home and community-based services;

(iii) Adult day health;

(iv) Medicaid personal care;

(v) Private duty nursing administered by the aging and disability services administration of the department; and

(vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(d) The following services provided on and after June 1, 2004 through December 31, 2009:

(i) All medicaid services, including those services described in subsection (c) of this section;

(ii) Medicare savings programs services for individuals also receiving medicaid;

(iii) Medicare premiums only for individuals also receiving medicaid; and

(iv) Premium payments to managed care organizations.

(e) The following services provided on or after January 1, 2010:

(i) All medicaid services except those defined under subsection (d)(ii) and (d)(iii) of this section;

(ii) All institutional medicaid services described in subsection (c) of this section;

(iii) Premium payments to managed care organizations; and

(iv) The client's proportional share of the state's monthly contribution to the centers for medicare and medicaid services (CMS) to defray the costs for outpatient prescription drug coverage provided to a person who is eligible for medicare Part D and medicaid.

(2) The client's estate is liable for all state-only funded long-term care services and related hospital and prescription drug services provided to:

(a) Home and community services' clients on and after July 1, 1995; and

(b) Division of developmental disabilities' clients on and after June 1, 2004.

(3) The client's estate is liable for all state-funded services provided regardless of the age of the client at the time the services were provided.

[Statutory Authority: RCW 74.08.090 and 2008 Medicare Improvements for Patient and Providers Act (which amended Section 1917 (b)(1)(B)(ii) of the Social Security Act); Deficit Reduction Act of 2005 (incorporating language regarding LTC partnership agreements). 10-08-110, § 388-527-2742, filed 4/7/10, effective 5/8/10. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2742, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2742, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2742, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2742, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2754 Assets not subject to recovery and other limits on recovery. (1) Recovery does not apply to the first fifty thousand dollars of the estate value at the time of death and is limited to thirty-five percent of the remaining value of the estate for services the client:

(a) Received before July 25, 1993; and

(b) When the client died with:

(i) No surviving spouse;

(ii) No surviving child who is:

(A) Under twenty-one years of age;

(B) Blind; or

(C) Disabled.

(iii) A surviving child who is twenty-one years of age or older.

(2) For services received after July 24, 1993, all services recoverable under WAC 388-527-2742 will be recovered, even from the first fifty thousand dollars of estate value that is exempt above, except as set forth in subsections (3) through (8) of this section.

(3) For a client who received services after July 24, 1993 and before July 1, 1994, the following property, up to a combined fair market value of two thousand dollars, is not recovered from the estate of the client:

(a) Family heirlooms;

(b) Collectibles;

(c) Antiques;

(d) Papers;

(e) Jewelry;

(f) Photos; and

(g) Other personal effects of the deceased client and to which a surviving child is entitled.

(4) Certain properties belonging to American Indians/Alaska natives (AI/AN) are exempt from estate recovery if at the time of death:

(a) The deceased client was enrolled in a federally recognized tribe; and

(b) The estate or heir documents the deceased client's ownership interest in trust or nontrust real property and improvements located on a reservation, near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior, or located:

(i) Within the most recent boundaries of a prior federal reservation; or

(ii) Within the contract health service delivery area boundary for social services provided by the deceased client's tribe to its enrolled members.

(5) Protection of trust and nontrust property under subsection (4) is limited to circumstances when the real property and improvements pass from an Indian (as defined in 25 U.S.C. Chapter 17, Sec. 1452(b)) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses and step-children, that their culture would nonetheless protect as family members, to a tribe or tribal organization and/or to one or more Indians.

(6) Certain AI/AN income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) are exempt from estate recovery by other laws and regulations.

(7) Ownership interests in or usage rights to items that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

(8) Government reparation payments specifically excluded by federal law in determining eligibility are exempt from estate recovery as long as such funds have been kept segregated and not commingled with other countable resources and remain identifiable.

(9) Assets protected under a qualified long term care partnership agreement.

[Statutory Authority: RCW 74.08.090 and 2008 Medicare Improvements for Patient and Providers Act (which amended Section 1917 (b)(1)(B)(ii) of the Social Security Act); Deficit Reduction Act of 2005 (incorporating language regarding LTC partnership agreements). 10-08-110, § 388-527-2754, filed 4/7/10, effective 5/8/10. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2754, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2754, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2754, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2790 Filing liens. (1) The department may file liens to recover the cost of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of a client consistent with 42 U.S.C. 1396p and chapters 43.20B RCW and 388-527 WAC.

(2) Prior to the department filing a lien under this section, the department sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The probate estate's personal representative, if any;

(c) Any other person known to have title to the affected property and/or to the decedent's heir(s) as defined by WAC 388-527-2730; and

(d) The decedent's last known address or the address listed on the title, if any.

(3) The notice in subsection (2) of this section includes:

(a) The decedent's name, identification number, date of birth, and date of death;

(b) The amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client that the department seeks to recover;

(c) The department's intent to file a lien against the deceased client's property and other assets to recover the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client;

(d) The county in which the property and other assets are located; and

(e) The procedures to contest the department's decision to file a lien by applying for an administrative hearing.

(4) An administrative hearing only determines:

(a) Whether the medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the decedent alleged by the department's notice is correct;

(b) Whether the decedent had legal title to the property; and

(c) Whether a lien is allowed under the provisions of Title 42 USC Section 1396p (a) and (b).

(5) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 388-527-2870, within twenty-eight calendar days of the date the department mailed the notice.

(6) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property and other assets of the time and place of the administrative hearing.

(7) Disputed assets must not be distributed while in litigation.

(8) An administrative hearing under this section is governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

(9) If an administrative hearing is conducted in accordance with this regulation, and the final agency decision is issued, the department only files a lien against the decedent's property and other assets only if upheld by the final agency decision.

(10) If no known title holder requests an administrative hearing, the department files a lien twenty-eight calendar days after the date the department mailed the notice described in subsection (2) of this section.

[Statutory Authority: RCW 74.08.090 and 2008 Medicare Improvements for Patient and Providers Act (which amended Section 1917 (b)(1)(B)(ii) of the Social Security Act); Deficit Reduction Act of 2005 (incorporating language regarding LTC partnership agreements). 10-08-110, § 388-527-2790, filed 4/7/10, effective 5/8/10. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2790, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2790, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2790, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2790, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2790, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2820 Liens prior to death. (1) Subject to the requirements of 42 USC Section 1396p and the conditions of this section, the department is authorized to file a lien against the property of a medical assistance client prior to his or her death, and to seek adjustment and recovery from the client's estate or sale of the property subject to the lien if:

(a) The client is permanently an inpatient in a nursing facility, intermediate care facility for individuals with mental retardation, or other medical institution as described in WAC 388-500-0005;

(b) The department determines, after notice and opportunity for a hearing, that the client cannot reasonably be expected to be discharged from the medical institution and return home; and

(c) None of the following are lawfully residing, in the client's home:

(i) The client's spouse or domestic partner;

(ii) The client's child who at the time of the client's death is twenty years of age or younger, or is blind or permanently and totally disabled as defined in Title 42 USC Section 1382c; or

(iii) A sibling of the client (who has an equity interest in such home and who was residing in the client's home for a period of at least one year immediately before the date of the client's admission to the medical institution).

(2) If the client is discharged from the medical facility and returns home, the department dissolves the lien.

(3) Prior to the department filing a lien under this section, the department sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The client's known address;

(c) Any other person known to have title to the affected property and the client's authorized representative, if any.

(4) The notice in subsection (3) of this section includes:

(a) The client's name, and the date the client began to receive services;

(b) The department's intent to file a lien against the client's property to recover the amount of medical assistance or state-only funded long-term care services, or both correctly paid on behalf of the client;

(c) The county in which the property and other assets are located; and

(d) The procedures to contest the department's decision to file a lien by applying for an administrative hearing.

(5) An administrative hearing only determines:

(a) Whether the medical assistance or state-only funded long-term care services, or both, on behalf of the decedent alleged by the department's notice is correct; and

(b) Whether the decedent had legal title to the identified property.

(6) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 388-527-2870, within twenty-eight calendar days of the date the department mailed the notice.

(7) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property of the time and place of the administrative hearing.

(8) Disputed assets must not be distributed while in litigation.

(9) An administrative hearing under this subsection is governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

(10) If an administrative hearing is conducted in accordance with this regulation, and the final agency decision is issued, the department only files a lien against the client's property and other assets only if upheld by the final agency decision.

(11) If no known title holder requests an administrative hearing, the department files a lien twenty-eight calendar days after the date the department mailed the notice described in subsection (3) of this section.

[Statutory Authority: RCW 74.08.090 and 2008 Medicare Improvements for Patient and Providers Act (which amended Section 1917 (b)(1)(B)(ii) of the Social Security Act); Deficit Reduction Act of 2005 (incorporating language regarding LTC partnership agreements). 10-08-110, § 388-527-2820, filed 4/7/10, effective 5/8/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and chapter 26.60 RCW. 09-07-038, § 388-527-2820, filed 3/10/09, effective 4/10/09. Statutory Authority: 2005 c 292, RCW 43.20B.-080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2820, filed 8/14/06, effective 9/14/06.]

Chapter 388-530 WAC
PRESCRIPTION DRUGS (OUTPATIENT)

WAC

388-530-4100 Washington preferred drug list (PDL).
388-530-4125 Generics first for a client's first course of treatment.
388-530-4150 Therapeutic interchange program (TIP).
388-530-8000 Reimbursement method—Estimated acquisition cost (EAC).

WAC 388-530-4100 Washington preferred drug list (PDL). Under RCW 69.41.190 and 70.14.050, the department and other state agencies cooperate in developing and maintaining the Washington preferred drug list.

(1) Washington state contracts with evidence-based practice center(s) for systematic reviews of drug(s).

(2) The pharmacy and therapeutics (P&T) committee reviews and evaluates the safety, efficacy, and outcomes of prescribed drugs, using evidence-based information provided by the evidence-based practice center(s).

(3) The P&T committee makes recommendations to state agencies as to which drug(s) to include on the Washington PDL under chapter 182-50 WAC.

(4) The appointing authority makes the final selection of drugs included on the Washington PDL.

(5) Drugs in a drug class on the Washington PDL that have been studied by the evidence-based practice center(s) and reviewed by the P&T committee and which have not been selected as preferred are considered nonpreferred drugs and are subject to the therapeutic interchange program (TIP) and dispense as written (DAW) rules under WAC 388-530-4150.

(6) Drugs in a drug class on the Washington PDL that have not been studied by the evidence-based practice center(s) and have not been reviewed by the P&T committee will be treated as nonpreferred drugs not subject to the dispense as written (DAW) or the therapeutic interchange program (TIP).

(7) A nonpreferred drug which the department determines as covered is considered for authorization after the client has:

(a) Tried and failed or is intolerant to at least one preferred drug; and

(b) Met department established criteria for the nonpreferred drug.

(8) Drugs in a drug class on the Washington PDL may be designated as preferred drugs for special populations or specific indications.

(9) Drugs in a drug class on the Washington PDL may require authorization for safety.

(10) Combination drugs that have been studied by the evidence-based practice center and have been reviewed by the P&T committee may be included in the Washington PDL.

(11) When a brand name drug has been reviewed by the P&T committee, the department may immediately designate an available, less expensive, equally effective, generic equivalent as a preferred drug. For the purpose of this chapter, generic equivalent drugs are those identified in the FDA's approved drug products with therapeutic equivalence evaluations (orange book).

(12) The dispensing of a brand name drug in a drug class on the Washington PDL as a client's first course of treatment

within that therapeutic class may be subject to restrictions under WAC 388-530-4125 and WAC 388-530-4150(10).

[Statutory Authority: RCW 74.04.050, 74.09.700, 74.08.090, 2009 c 575. 10-06-011, § 388-530-4100, filed 2/19/10, effective 3/22/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.700, 2008 c 245. 08-21-107, § 388-530-4100, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-4100, filed 9/26/07, effective 11/1/07.]

WAC 388-530-4125 Generics first for a client's first course of treatment. The department uses point-of-sale (POS) claim messaging to communicate to pharmacies to use a preferred generic drug for the client's first course of treatment in specific drug classes.

(1) The department may require preferred generic drug(s) on the Washington preferred drug list (PDL) be used before any brand name drugs for a client's first course of treatment within that therapeutic class of drugs, when:

(a) There is a less expensive, equally effective therapeutic alternative generic product available to treat the condition; and

(b) The drug use review (DUR) board established under WAC 388-530-4000 has reviewed the drug class and recommended to the department that the drug class is appropriate to require generic drugs as a client's first course of treatment.

(2) For drug classes selected by the department which meet the criteria of subsection (1) of this section, only preferred generic drugs are covered for a client's first course of treatment, except as identified in subsection (3) of this section.

(3) Endorsing practitioners' prescriptions written "Dispense as written (DAW)" for preferred and nonpreferred brand name drugs and nonpreferred generics in the specific drug classes on the Washington PDL reviewed by the DUR board will be subject to authorization to establish medical necessity as defined in WAC 388-500-0005.

[Statutory Authority: RCW 74.04.050, 74.09.700, 74.08.090, 2009 c 575. 10-06-011, § 388-530-4125, filed 2/19/10, effective 3/22/10.]

WAC 388-530-4150 Therapeutic interchange program (TIP). This section contains the department's rules for the endorsing practitioner therapeutic interchange program (TIP). TIP is established under RCW 69.41.190 and 70.14.-050. The statutes require state-operated prescription drug programs to allow physicians and other prescribers to endorse a Washington preferred drug list (PDL) and, in most cases, requires pharmacists to automatically substitute a preferred, equivalent drug from the list.

(1) The therapeutic interchange program (TIP) applies only to drugs:

(a) Within therapeutic classes on the Washington PDL;

(b) Studied by the evidence-based practice center(s);

(c) Reviewed by the pharmacy and therapeutics (P&T) committee; and

(d) Prescribed by an endorsing practitioner.

(2) TIP does not apply:

(a) When the P&T committee determines that TIP does not apply to the therapeutic class on the PDL; or

(b) To a drug prescribed by a nonendorsing practitioner.

(3) A practitioner who wishes to become an endorsing practitioner must specifically enroll with the health care authority (HCA) as an endorsing practitioner under the provisions of chapter 182-50 WAC and RCW 69.41.190(2).

(4) When an endorsing practitioner writes a prescription for a client for a nonpreferred drug, or for a preferred drug for a special population or indication other than the client's population or indication, and indicates that substitution is permitted, the pharmacist must:

(a) Dispense a preferred drug in that therapeutic class in place of the nonpreferred drug; and

(b) Notify the endorsing practitioner of the specific drug and dose dispensed.

(5) With the exception of subsection (7) and (10) of this section, when an endorsing practitioner determines that a nonpreferred drug is medically necessary, all of the following apply:

(a) The practitioner must indicate that the prescription is to be dispensed as written (DAW);

(b) The pharmacist dispenses the nonpreferred drug as prescribed; and

(c) The department does not require prior authorization to dispense the nonpreferred drug in place of a preferred drug except when the drug requires authorization for safety.

(6) In the event the following therapeutic drug classes are on the Washington PDL, pharmacists will not substitute a preferred drug for a nonpreferred drug in these therapeutic drug classes when the endorsing practitioner prescribes a refill (including the renewal of a previous prescription or adjustments in dosage):

(a) Antipsychotic;

(b) Antidepressant;

(c) Antiepileptic;

(d) Chemotherapy;

(e) Antiretroviral;

(f) Immunosuppressive; or

(g) Immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

(7) The department may impose nonendorsing status on an endorsing practitioner only under the following circumstances:

(a) The department runs three quarterly reports demonstrating that, within any therapeutic class of drugs on the Washington PDL, the endorsing practitioner's frequency of prescribing DAW varies from the prescribing patterns of the endorsing practitioner's department-designated peer grouping with a ninety-five percent confidence interval; and

(b) The medical director has:

(i) Delivered by mail to the endorsing practitioner the quarterly reports described in subsection (7)(a) of this section which demonstrate the endorsing practitioner's variance in prescribing patterns; and

(ii) Provided the endorsing practitioner an opportunity to explain the variation in prescribing patterns as medically necessary as defined under WAC 388-500-0005; or

(iii) Provided the endorsing practitioner two calendar quarters to change his or her prescribing patterns to align with those of the department-designated peer groupings.

(8) While the endorsing practitioner is engaged in the activities described in subsection (7)(b)(ii) or (7)(b)(iii) of

this section, his or her endorsing practitioner status is maintained.

(9) The nonendorsing status restrictions imposed under this section will remain in effect until the quarterly reports demonstrate that the endorsing practitioner's prescribing patterns no longer vary in comparison to his or her department designated peer-grouping over a period of four calendar quarters, with a ninety-five percent confidence interval.

(10) Except as otherwise provided in subsection (11) of this section, for a client's first course of treatment within a therapeutic class of drugs, the endorsing practitioner's option to write DAW does not apply when:

(a) There is a less expensive, equally effective therapeutic alternative generic product available to treat the condition; and

(b) The drug use review (DUR) board established under WAC 388-530-4000 has reviewed the drug class and recommended to the department that the drug class is appropriate to require generic drugs as a client's first course of treatment.

(11) In accordance with WAC 388-530-4125(3) and WAC 388-501-0165, the department will request and review the endorsing practitioner's medical justification for preferred and nonpreferred brand name drugs and nonpreferred generic drugs for the client's first course of treatment.

[Statutory Authority: RCW 74.04.050, 74.09.700, 74.08.090, 2009 c 575. 10-06-011, § 388-530-4150, filed 2/19/10, effective 3/22/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.700, 2008 c 245. 08-21-107, § 388-530-4150, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-4150, filed 9/26/07, effective 11/1/07.]

WAC 388-530-8000 Reimbursement method—Estimated acquisition cost (EAC). (1) The department determines estimated acquisition cost (EAC) using:

(a) Acquisition cost data made available to the department; or

(b) Information provided by any of the following:

(i) Audit agencies, federal or state;

(ii) Other state health care purchasing agencies;

(iii) Pharmacy benefit managers;

(iv) Individual pharmacy providers participating in the department's programs;

(v) Centers for Medicare and Medicaid Services (CMS);

(vi) Other third party payers;

(vii) Drug file data bases; and/or

(viii) Actuaries or other consultants.

(2) The department implements EAC by applying a percentage adjustment to available reference pricing from national sources such as wholesale acquisition cost, average wholesale price (AWP), average sale price (ASP), and average manufacturer price (AMP).

(3) The department may set EAC for specified drugs or drug categories at a maximum allowable cost other than that determined in subsection (1)(a) of this section when the department considers it necessary. The factors the department considers in setting a rate for a class of drugs under this subsection include, but are not limited to:

(a) Product acquisition cost;

(b) The department's documented clinical concerns; and

(c) The department's budget limits.

(4) The department bases EAC drug reimbursement on the actual package size dispensed.

(5) The department uses EAC as the department's reimbursement for a drug when EAC is the lowest of the rates calculated under the methods listed in WAC 388-530-7000, or when the conditions of WAC 388-530-7300 are met.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 10-24-021, § 388-530-8000, filed 11/19/10, effective 12/20/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-8000, filed 9/26/07, effective 11/1/07.]

Chapter 388-531 WAC
PHYSICIAN-RELATED SERVICES

WAC

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WAC 388-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

"Acquisition cost" means the cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" means care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" means a comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at a department-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 388-550-2501).

"Add-on procedure(s)" means secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" means the medical condition responsible for a hospital admission, as defined by ICD-9-M diagnostic code.

"Advanced registered nurse practitioner (ARNP)" means a registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Aging and disability services administration (ADSA)" means the administration that administers directly or contracts for long-term care services, including but not limited to nursing facility care and home and community services. See WAC 388-71-0202.

"Allowed charges" means the maximum amount reimbursed for any procedure that is allowed by the department.

"Anesthesia technical advisory group (ATAG)" means an advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" means any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" means a number of anesthesia units assigned to a surgical procedure that includes the usual pre-operative, intra-operative, and post-operative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" means services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" means supplies which are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

"By report (BR)" means a method of reimbursement in which the department determines the amount it will pay for a service that is not included in the department's published fee schedules. The department may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

"Call" means a face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" means a reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Centers for Medicare and Medicaid Services (CMS)" means the agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for medicare and medicaid programs.

"Certified registered nurse anesthetist (CRNA)" means an advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the National Certification and scope of practice.

"Children's health insurance plan (CHIP)," see chapter 388-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" means regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" means dollar amounts the department uses to calculate the maximum allowable fee for physician-related services.

"Covered service" means a service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" means physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Diagnosis code" means a set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"Emergency medical condition(s)" means a medical condition(s) that manifests itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Emergency services" means medical services required by and provided to a patient experiencing an emergency medical condition.

"Estimated acquisition cost (EAC)" means the department's best estimate of the price providers generally and currently pay for drugs and supplies.

"Evaluation and management (E&M) codes" means procedure codes which categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" means the process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to the department which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. See WAC 388-531-0550. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the FDA or other requisite government body, if such approval is required.

"Fee-for-service" means the general payment method the department uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under the department's healthy options program or children's health insurance program (CHIP) programs.

"Flat fee" means the maximum allowable fee established by the department for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" as defined by medicare, means a medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 388-531-1700.

"HCPCS Level II" means a coding system established by CMS (formerly known as the Health Care Financing Administration) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" means the name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" means a group of health care providers involved in the care of a client.

"Hospice" means a medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD-9-CM," see "International Classification of Diseases, 9th Revision, Clinical Modification."

"Informed consent" means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and

(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and

(3) Given the client a copy of the consent form; and

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(5) Given the client oral information about all of the following:

(a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" means an admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alpha-numerical designations (coding).

"Investigational" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to be of greater overall benefit to the client in the particular circumstance than another, generally available service.

"Life support" means mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension" means a process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which the department routinely reimburses. Limitation extensions require prior authorization.

"Maximum allowable fee" means the maximum dollar amount that the department will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 388-500-0005.

"Medicare physician fee schedule data base (MPFSDB)" means the official HCFA publication of the medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare program fee schedule for physician services (MPFSPS)" means the official HCFA publication of the medicare fees for physician services.

"Medicare clinical diagnostic laboratory fee schedule" means the fee schedule used by medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Peer-reviewed medical literature" means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

"Physician care plan" means a written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" means physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "CPT, current procedural terminology."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" means the diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Pound indicator (#)" means a symbol (#) indicating a CPT procedure code listed in the department's fee schedules that is not routinely covered.

"Preventive" means medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization" means a process by which clients or providers must request and receive the department approval for certain medical services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

"Professional component" means the part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" means the probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" means face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 388-500-0005.

"Radioallergosorbent test" or **"RAST"** means a blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RVU," see relative value unit.

"Reimbursement" means payment to a provider or other department-approved entity who bills according to the provisions in WAC 388-502-0100.

"Reimbursement steering committee (RSC)" means an interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, the department, and department of labor and industries.

"Relative value guide (RVG)" means a system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" means a unit which is based on the resources required to perform an individual service or intervention.

"Resource based relative value scale (RBRVS)" means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"RBRVS RVU" means a measure of the resources required to perform an individual service or intervention. It is set by medicare based on three components - physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"RSC RVU" means a unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"Stat laboratory charges" means charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" means a tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by HCFA to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" means an advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, the department, and department of labor and industries.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0050, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-059, § 388-531-0050, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-081, § 388-531-0050, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090. 03-06-049, § 388-531-0050, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0150 Noncovered physician-related services—General and administrative. (1) Except as provided in WAC 388-531-0100 and subsection (2) of this section, the department does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(e) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 388-501-0165;

(f) Hair transplantation;

(g) Marital counseling or sex therapy;

(h) More costly services when the department determines that less costly, equally effective services are available;

(i) Vision-related services listed as noncovered in chapter 388-544 WAC;

(j) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 388-531-1750;

(k) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(l) Physical examinations or routine checkups, except as provided in WAC 388-531-0100;

(m) Routine foot care. This does not include clients who have a medical condition that affects the feet, such as diabetes or arteriosclerosis obliterans. Routine foot care includes, but is not limited to:

(i) Treatment of mycotic disease;

(ii) Removal of warts, corns, or calluses;

(iii) Trimming of nails and other hygiene care; or

(iv) Treatment of flat feet;

(n) Except as provided in WAC 388-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services.

(o) Nonmedical equipment; and

(p) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas.

(2) The department covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A medicaid program for qualified **medicare** beneficiaries (QMBs); or

(c) A waiver program.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 05-12-022, § 388-531-0150, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0200 Physician-related services requiring prior authorization. (1) The department requires **prior authorization** for certain services. Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE).** See WAC 388-501-0165.

(2) The EPA process is designed to eliminate the need for telephone prior authorization for selected admissions and procedures.

(a) The provider must create an authorization number using the process explained in the department's physician-related billing instructions.

(b) Upon request, the provider must provide supporting clinical documentation to the department showing how the authorization number was created.

(c) Selected nonemergent admissions to contract hospitals require EPA. These are identified in the department billing instructions.

(d) Procedures requiring expedited prior authorization include, but are not limited to, the following:

(i) Bladder repair;

(ii) Hysterectomy for clients age forty-five and younger, except with a diagnosis of cancer(s) of the female reproductive system;

(iii) Outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA);

(iv) Reduction mammoplasties/mastectomy for geynecomastia; and

(v) Strabismus surgery for clients eighteen years of age and older.

(3) The department evaluates new technologies under the procedures in WAC 388-531-0550. These require prior authorization.

(4) Prior authorization is required for the following:

(a) Abdominoplasty;

(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R);**

(c) Cochlear implants, which also:

(i) For coverage, must be performed in an ambulatory surgery center (ASC) or an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim;

(d) Diagnosis and treatment of eating disorders for clients twenty-one years of age and older;

(e) Osteopathic manipulative therapy in excess of the department's published limits;

(f) Panniculectomy;

(g) Bariatric surgery (see WAC 388-531-1600); and

(h) Vagus nerve stimulator insertion, which also:

(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim.

(5) The department may require a second opinion and/or consultation before authorizing any elective surgical procedure.

(6) Children six year of age and younger do not require authorization for hospitalization.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 05-12-022, § 388-531-0200, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0300 Anesthesia providers and covered physician-related services. The department bases coverage of anesthesia services on medicare policies and the following rules:

(1) The department reimburses providers for covered anesthesia services performed by:

(a) Anesthesiologists;

(b) **Certified registered nurse anesthetists (CRNAs);**

(c) Oral surgeons with a special agreement with the department to provide anesthesia services; and

(d) Other providers who have a special agreement with the department to provide anesthesia services.

(2) The department covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) The department covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC 388-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC 388-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a preanesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) The department does not allow the anaesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by medicare instructions.

(6) The department requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, the department reimburses the base anesthesia units (BAU) for the major procedure only.

(b) The department does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, the department reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, the department limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) The department pays CRNAs or anesthesiologists for pain management services.

(b) The department allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) The department does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 388-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 388-533 WAC for more information about maternity-related services.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0350 Anesthesia services—Reimbursement for physician-related services. (1) The department reimburses anesthesia services on the basis of base anesthesia units (BAU) plus time.

(2) The department calculates payment for anesthesia by adding the BAU to the time units and multiplying that sum by the conversion factor. The formula used in the calculation is: (BAU x fifteen) + time) x (conversion factor divided by fifteen) = reimbursement.

(3) The department obtains BAU values from the relative value guide **(RVG)**, and updates them annually. The department and/or the anesthesia technical advisory group **(ATAG)** members establish the base units for procedures for which anesthesia is appropriate but do not have BAUs established by RVSP and are not defined as add-on.

(4) The department determines a budget neutral anesthesia conversion factor by:

(a) Determining the BAUs, time units, and expenditures for a **base period** for the provided procedure. Then,

(b) Adding the latest BAU RVSP to the time units for the base period to obtain an estimate of the new time unit for the procedure. Then,

(c) Multiplying the time units obtained in (b) of this subsection for the new period by a conversion factor to obtain estimated expenditures. Then,

(d) Comparing the expenditures obtained in (c) of this subsection with base period expenditure levels obtained in (a) of this subsection. Then,

(e) Adjusting the dollar amount for the anesthesia conversion factor and the projected time units at the new BAUs

equals the allocated amount determined in (a) of this subsection.

(5) The department calculates anesthesia time units as follows:

(a) One minute equals one unit.

(b) The total time is calculated to the next whole minute.

(c) Anesthesia time begins when the anesthesiologist, surgeon, or CRNA begins physically preparing the client for the induction of anesthesia; this must take place in the operating room or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be added together as long as there is continuous monitoring. Examples of this include, but are not limited to, the following:

(i) The time a client spends in an anesthesia induction room; or

(ii) The time a client spends under the care of an operating room nurse during a surgical procedure.

(d) Anesthesia time ends when the anesthesiologist, surgeon, or CRNA is no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(6) The department changes anesthesia **conversion factors** if the legislature grants a vendor rate increase, or other increase, and if the effective date of that increase is not the same as the department's annual update.

(7) If the legislatively authorized vendor rate increase or other increase becomes effective at the same time as the department's annual update, the department applies the increase after calculating the budget-neutral conversion factor.

(8) When more than one surgical procedure is performed at the same operative session, the department uses the BAU of the major procedure to determine anesthesia **allowed charges.** The department reimburses for add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0450 Critical care—Physician-related services. (1) The department reimburses the following physicians for critical care services:

(a) The attending physician who assumes responsibility for the care of a client during a life-threatening episode;

(b) More than one physician if the services provided involve multiple organ systems; or

(c) Only one physician for services provided in the emergency room.

(2) The department reimburses preoperative and postoperative critical care in addition to a **global surgical package** when all the following apply:

(a) The client is critically ill and the physician is engaged in work directly related to the individual client's care, whether that time is spent at the immediate bedside or elsewhere on the floor;

(b) The critical injury or illness acutely impairs one or more vital organ systems such that the client's survival is jeopardized;

(c) The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and

(d) The provider uses any necessary, appropriate modifier when billing the department.

(3) The department limits payment for critical care services to a maximum of three hours per day, per client.

(4) The department does not pay separately for certain services performed during a critical care period when the services are provided on a per hour basis. These services include, but are not limited to, the following:

(a) Analysis of information data stored in computers (e.g., ECG, blood pressure, hematologic data);

(b) Blood draw for a specimen;

(c) Blood gases;

(d) Cardiac output measurement;

(e) Chest X rays;

(f) Gastric intubation;

(g) Pulse oximetry;

(h) Temporary transcutaneous pacing;

(i) Vascular access procedures; and

(j) Ventilator management.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0450, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0500 Emergency physician-related services. (1) The department reimburses for E&M services provided in the hospital emergency department to clients who arrive for immediate medical attention.

(2) The department reimburses emergency physician services only when provided by physicians assigned to the hospital emergency department or the physicians on **call** to cover the hospital emergency department.

(3) The department pays a provider who is called back to the emergency room at a different time on the same day to attend a return visit [to] the same client. When this results in multiple claims on the same day, the time of each encounter must be clearly indicated on the claim.

(4) The department does not pay emergency room physicians for **hospital admission** charges or additional service charges.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0500, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0550 Experimental and investigational services. (1) When the department makes a determination as to whether a proposed service is experimental or investigational, the department follows the procedures in this section. The policies and procedures and any criteria for making decisions are available upon request.

(2) The determination of whether a service is experimental and/or investigational is subject to a case-by-case review under the provisions of WAC 388-501-0165 which relate to medical necessity. The department also considers the following:

(a) Evidence in **peer-reviewed medical literature**, as defined in WAC 388-531-0050, and preclinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's

length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications;

(b) Whether evidence indicates the service or treatment is more likely than not to be as beneficial as existing conventional treatment alternatives for the treatment of the condition in question;

(c) Whether the service or treatment is generally used or generally accepted for treatment of the condition in the United States;

(d) Whether the service or treatment is under continuing scientific testing and research;

(e) Whether the service or treatment shows a demonstrable benefit for the condition;

(f) Whether the service or treatment is safe and efficacious;

(g) Whether the service or treatment will result in greater benefits for the condition than another generally available service; and

(h) If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

(3) The department applies consistently across clients with the same medical condition and health status, the criteria to determine whether a service is experimental. A service or treatment that is not experimental for one client with a particular medical condition is not determined to be experimental for another enrollee with the same medical condition and health status. A service that is experimental for one client with a particular medical condition is not necessarily experimental for another, and subsequent individual determinations must consider any new or additional evidence not considered in prior determinations.

(4) The department does not determine a service or treatment to be experimental or investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of greater overall benefit to the client in question than another generally available service.

(5) All determinations that a proposed service or treatment is "experimental" or "investigation" are subject to the review and approval of a physician who is:

(a) Licensed under chapter 18.57 RCW or an osteopath licensed under chapter 18.71 RCW;

(b) Designated by the department's medical director to issue such approvals; and

(c) Available to consult with the client's treating physician by telephone.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0550, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0600 HIV/AIDS counseling and testing as physician-related services. The department covers one pre- and one post-HIV/AIDS counseling/testing session per client each time the client is tested for HIV/AIDS.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0600, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0600, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0650 Hospital physician-related services not requiring authorization when provided in department-approved centers of excellence or hospitals authorized to provide the specific services. The department covers the following services without prior authorization when provided in department-approved centers of excellence. The department issues periodic publications listing centers of excellence. These services include the following:

(1) All transplant procedures specified in WAC 388-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400. See also WAC 388-531-0700;

(3) Sleep studies including but not limited to polysomnograms for clients one year of age and older. The department allows sleep studies only in outpatient hospital settings as described under WAC 388-550-6350. See also WAC 388-531-1500; and

(4) Diabetes education, in a DOH-approved facility, per WAC 388-550-6300.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0650, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 05-12-022, § 388-531-0650, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0700 Inpatient chronic pain management physician-related services. (l) The department covers inpatient chronic pain management services only when the services are obtained through a department-approved chronic pain facility.

(2) A client qualifies for inpatient chronic pain management services when all of the following apply:

(a) The client has had chronic pain for at least three months, that has not improved with conservative treatment, including tests and therapies;

(b) At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and

(c) Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.

(3) For chronic pain management, the department limits coverage to only one inpatient hospital stay per client's lifetime, up to a maximum of twenty-one days.

(4) The department reimburses for only the chronic pain management services and procedures that are listed in the fee schedule.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0700, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0750 Inpatient hospital physician-related services. (1) The department separately reimburses the attending provider for inpatient hospital professional services rendered by the attending provider during the surgical follow-up period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) The department reimburses for only one inpatient hospital call per client, per day for the same or related diagnoses. If a call is included in the **global surgery reimbursement,** the department does not reimburse separately.

(3) The department reimburses a hospital admission related to a planned surgery through the global fee for surgery.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0750, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0800 Laboratory and pathology physician-related services. (1) The department reimburses providers for laboratory services only when:

(a) The provider is certified according to Title XVII of the Social Security Act (medicare), if required; and

(b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) The department includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.

(3) The department reimburses only one blood drawing fee per client, per day. The department allows additional reimbursement for an independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.

(4) The department reimburses only one catheterization for collection of a urine specimen per client, per day.

(5) The department reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, the department reimburses the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

(i) A clinic;

(ii) A hospital laboratory;

(iii) An independent laboratory; or

(iv) A physician's office.

(6) The department allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) The department reimburses STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order, the physician must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) The department reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) The department does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-contracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) The department does not cover for drug screens to monitor any of the following:

(a) Program compliance in either a residential or outpatient drug or alcohol treatment program;

(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or

(c) Suspected drug use by clients in a residential setting, such as a group home.

(10) The department may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill the department directly. The department does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0800, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0800, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0850 Laboratory and pathology physician-related services reimbursement. (1) The department pays for clinical diagnostic laboratory procedures based on the **medicare clinical diagnostic laboratory fee schedule (MCDLF)** for the state of Washington. The department obtains information used to update fee schedule regulations from Program Memorandum and Regional Medicare Letters as published by HCFA.

(2) The department updates budget-neutral fees each July by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Determining in total the ratio of current department fees to existing medicare fees. Then,

(c) Determining new department fees by adjusting the new medicare fee by the ratio. Then,

(d) Multiplying the units of service by the new department fee to obtain total estimated expenditures. Then,

(e) Comparing the expenditures in subsection (14)(d) of this section to the base period expenditures. Then,

(f) Adjusting the new ratio until estimated expenditures equals the base period amount.

(3) The department calculates maximum allowable fees (MAF) by:

(a) Calculating fees using methodology described in subsection (2) of this section for procedure codes that have an applicable medicare clinical diagnostic laboratory fee (MCDLF).

(b) Establishing **RSC** fees for procedure codes that have no applicable MCDLF.

(c) Establishing maximum allowable fees, or **"flat fees"** for procedure codes that have no applicable MCDLF or RSC fees. The department updates flat fee reimbursement only when authorized by the legislature.

(d) The department reimbursement for clinical laboratory diagnostic procedures does not exceed the regional MCDLF schedule.

(4) The department increases fees if the legislature grants a vendor rate increase or other increase. If the legislatively authorized increase becomes effective at the same time as the department's annual update, the department applies the increase after calculating budget-neutral fees.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0850, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0900 Neonatal intensive care unit (NICU) physician-related services. (1) The department pays the physician directing the care of a neonate or infant in an NICU, for NICU services.

(2) NICU services include, but are not limited to, any of the following:

(a) Patient management;

(b) Monitoring and treatment of the neonate, including nutritional, metabolic and hematologic maintenance;

(c) Parent counseling; and

(d) Personal direct supervision by the **health care team** of activities required for diagnosis, treatment, and supportive care of the patient.

(3) Payment for NICU care begins with the date of admission to the NICU.

(4) The department reimburses a provider for only one NICU service per client, per day.

(5) A provider may bill for NICU services in addition to **prolonged services** and newborn resuscitation when the provider is present at the delivery.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0900, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0900, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0950 Office and other outpatient physician-related services. (l) The department reimburses for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and.

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 388-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (l) of this section.

(3) See physician billing instructions for procedures that are included in the office call and cannot be billed separately.

(4) Using selected diagnosis codes, the department reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) The department may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and purchased by the provider from a pharmacist or drug manufacturer as described in WAC 388-530-1200.

(6) The department does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) The department does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; the department does reimburse an administrative fee. If the immunization is given in a health department and is the only service provided, the department reimburses a minimum E&M service.

(8) The department reimburses immunizations at **estimated acquisition costs (EAC)** when the immunizations are not part of the vaccine for children program. The department reimburses a separate administration fee for these immunizations. Covered immunizations are listed in the fee schedule.

(9) The department reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) The department does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. The department does pay separately for the administration of these injections when they are provided on the same day as an E&M service. The department does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. The department reimburses separately for the drug(s).

(b) The department does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, the department pays an administrative fee. The department reimburses separately for the drug.

(c) The department reimburses injectable drugs at **acquisition cost.** The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by the department. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing the department for the following drugs:

(i) Classified drugs where the billed charge to the department is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to the department is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) The department reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, the department reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) The department covers the antigen, the antigen preparation, and an administration fee.

(e) The department reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) The department reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) The department reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on the medicare pricing method for calculating the estimated acquisition cost (EAC), or maximum allowable cost (MAC) when generics are available;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The national drug code (NCD) [NDC].

(12) Notwithstanding the provisions of this section, the department reserves the option of determining drug pricing for any particular drug based on the best evidence available to the department, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) The department may request an invoice as necessary.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-0950, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-0950, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1050 Osteopathic manipulative treatment. (1) The department reimburses osteopathic manipulative therapy (OMT) only when OMT is provided by an osteopathic physician licensed under chapter 18.71 RCW.

(2) The department reimburses OMT only when the provider bills using the appropriate CPT codes that involve the number of body regions involved.

(3) The department allows an osteopathic physician to bill the department for an evaluation and management (E&M) service in addition to the OMT when one of the following apply:

(a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

(4) The department limits reimbursement for manipulations to ten per client, per calendar year. Reimbursement for each manipulation includes a brief evaluation as well as the manipulation.

(5) The department does not reimburse for physical therapy services performed by osteopathic physicians.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1050, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1100 Out-of-state physician services. (1) The department covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC 388-501-0180.

(2) Out-of-state border areas as described under WAC 388-501-0175 are not subject to out-of-state limitations. The department considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1100, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1100, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1150 Physician care plan oversight services. (1) The department covers **physician care plan** oversight services only when:

(a) A physician provides the service; and

(b) The client is served by a home health agency, a nursing facility, or a **hospice.**

(2) The department reimburses for physician care plan oversight services when both of the following apply:

(a) The facility/agency has established a plan of care; and

(b) The physician spends thirty or more minutes per calendar month providing oversight for the client's care.

(3) The department reimburses only one physician per client, per month, for physician care plan oversight services.

(4) The department reimburses for physician care plan oversight services during the global surgical reimbursement period only when the care plan oversight is unrelated to the surgery.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1150, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1200 Physician office medical supplies. (1) Refer to RBRVS billing instructions for a list of:

(a) Supplies that are a routine part of office or other outpatient procedures and that cannot be billed separately; and

(b) Supplies that can be billed separately and that the department considers nonroutine to office or outpatient procedures.

(2) The department reimburses at acquisition cost certain supplies under fifty dollars that do not have a maximum allowable fee listed in the fee schedule. The provider must retain invoices for these items and make them available to the department upon request.

(3) Providers must submit invoices for items costing fifty dollars or more.

(4) The department reimburses for **sterile tray** for certain surgical services only. Refer to the fee schedule for a list of covered items.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1250 Physician standby services. (1) The department reimburses **physician standby** services only when the standby physician does not provide care or service to other clients during this period, and either:

(a) The services are provided in conjunction with newborn care history and examination, or result in an admission to a neonatal intensive care unit on the same day; or

(b) A physician requests another physician to stand by, resulting in the prolonged attendance by the second physician without face-to-face client contact.

(2) The department does not reimburse physician standby services when any of the following occur:

(a) The standby ends in a surgery or procedure included in a global surgical reimbursement;

(b) The standby period is less than thirty minutes; or

(c) Time is spent proctoring another physician.

(3) One unit of physician standby service equals thirty minutes. The department reimburses subsequent periods of physician standby service only when full thirty minutes of standby is provided for each unit billed. The department rounds down fractions of a thirty-minute time unit.

(4) The provider must clearly document the need for physician standby services in the client's medical record.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1250, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1250, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1300 Podiatric physician-related services. (1) The department covers podiatric services as listed in this section when provided by any of the following:

(a) A medical doctor;

(b) A doctor of osteopathy; or

(c) A podiatric physician.

(2) The department reimburses for the following:

(a) Nonroutine foot care when a medical condition that affects the feet (such as diabetes or arteriosclerosis obliterans) requires that any of the providers in subsection (1) of this section perform such care;

(b) One treatment in a sixty-day period for debridement of nails. The department covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) Impression casting. The department includes ninety-day follow-up care in the reimbursement;

(d) A surgical procedure performed on the ankle or foot, requiring a local nerve block, and performed by a qualified provider. The department does not reimburse separately for the anesthesia, but includes it in the reimbursement for the procedure; and

(e) Custom fitted and/or custom molded orthotic devices:

(i) The department's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) The department includes an E&M fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(3) The department does not reimburse podiatrists for any of the following radiology services:

(a) X rays for soft tissue diagnosis;

(b) Bilateral X rays for a unilateral condition;

(c) X rays in excess of two views;

(d) X rays that are ordered before the client is examined; or

(e) X rays for any part of the body other than the foot or ankle.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1350 Prolonged physician-related service. (1) The department reimburses prolonged services based on established medicare guidelines. The services provided may or may not be continuous. The services provided must meet both of the following:

(a) Consist of face-to-face contact between the physician and the client; and

(b) Be provided with other services.

(2) The department allows reimbursement for a prolonged service procedure in addition to an E&M procedure or consultation, up to three hours per client, per diagnosis, per day, subject to other limitations in the CPT codes that may be used. The applicable CPT codes are indicated in the fee schedule.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1450 Radiology physician-related services. (1) The department reimburses radiology services subject to the limitations in this section and under WAC 388-531-0300.

(2) The department does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Preexisting renal insufficiency; and/or

(g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) The department reimburse separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by the department, and reimbursement is at acquisition cost.

(4) The department reimburses general anesthesia for radiology procedures. See WAC 388-531-0300.

(5) The department reimburses radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC 388-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) The department reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate **professional component** modifier.

(7) The department reimburses for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of contract [contrast] media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column or skull.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1450, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1500 Sleep studies. (1) The department covers sleep studies only when all of the following apply:

(a) The study is done to establish a diagnosis of narcolepsy or of sleep apnea;

(b) The study is done only at a department-approved sleep study center that meets the standards and conditions in subsections (2), (3), and (4) of this section; and

(c) An ENT consultation has been done for a client under ten years of age.

(2) In order to become a department-approved sleep study center, a sleep lab must send to the department verification of both of the following:

(a) Sleep lab accreditation by the American Academy of Sleep Medicine; and

(b) Physician's Board Certification by the American Board of Sleep Medicine.

(3) Registered polysomnograph technicians (PSGT) must meet the accreditation standards of the American Academy of Sleep Medicine.

(4) When a sleep lab changes directors, the department requires the provider to submit accreditation for the new director. If an accredited director moves to a facility that the department has not approved, the provider must submit certification for the facility.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1500, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1550 Sterilization physician-related services. (1) For purposes of this section, sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. A hysterectomy is a surgical procedure or operation for the purpose of removing the uterus. Hysterectomy results in sterilization, but the department does not cover hysterectomy performed solely for that purpose. Both hysterectomy and sterilization procedures require the use of specific consent forms. See subsections (10), (11) and (12) of this section for additional coverage criteria for hysteroscopic sterilizations.

STERILIZATION

(2) The department covers sterilization when all of the following apply:

(a) The client is at least eighteen years of age at the time consent is signed;

(b) The client is a mentally competent individual;

(c) The client has voluntarily given **informed consent** in accordance with all the requirements defined in this subsection; and

(d) At least thirty days, but not more than one hundred eighty days, have passed between the date the client gave informed consent and the date of the sterilization.

(3) The department does not require the thirty-day waiting period, but does require at least a seventy-two hour waiting period, for sterilization in the following circumstances:

(a) At the time of premature delivery, the client gave consent at least thirty days before the expected date of delivery. The expected date of delivery must be documented on the consent form;

(b) For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

(4) The department waives the thirty-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, and completes a sterilization consent form. One of the following circumstances must apply:

(a) The client became eligible for **medical assistance** during the last month of pregnancy;

(b) The client did not obtain medical care until the last month of pregnancy; or

(c) The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery.

(5) The department does not accept informed consent obtained when the client is in any of the following conditions:

(a) In labor or childbirth;

(b) Seeking to obtain or obtaining an abortion; or

(c) Under the influence of alcohol or other substances that affect the client's state of awareness.

(6) The department has certain consent requirements that the provider must meet before the department reimburses sterilization of a **mentally incompetent** or institutionalized client. The department requires both of the following:

(a) A court order; and

(b) A sterilization consent form signed by the legal guardian, sent to the department at least thirty days prior to the procedure.

(7) The department reimburses epidural anesthesia in excess of the six-hour limit for sterilization procedures that are performed in conjunction with or immediately following a delivery. The provider cannot bill separately for BAUs for the sterilization procedure. The department determines total billable units by:

(a) Adding the time for the sterilization procedure to the time for the delivery; and

(b) Determining the total billable units by adding together the delivery BAUs, the delivery time, and the sterilization time.

(8) The physician identified in the "consent to sterilization" section of the DSHS-approved sterilization consent form must be the same physician who completes the "physician's statement" section and performs the sterilization procedure. If a different physician performs the sterilization procedure, the client must sign and date a new consent form at the time of the procedure that indicates the name of the physician performing the operation under the "consent for sterilization"

section. This modified consent must be attached to the original consent form when the provider bills the department.

(9) The department reimburses all attending providers for the sterilization procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. The department reimburses after the procedure is completed.

HYSTEROSCOPIC STERILIZATIONS

(10) The department pays for hysteroscopic sterilizations when the following criteria are met:

(a) A department-approved device is used;

(b) The procedure is predominately performed in a clinical setting such as a physician's office, without general anesthesia and without the use of a surgical suite; and is covered according to the corresponding department fee schedule;

(c) The client provides informed consent for the procedure in accordance with this section; and

(d) The hysteroscopic sterilization is performed by a department-approved provider who:

(i) Has a core provider agreement with the department;

(ii) Is nationally board certified in obstetrics and gynecology (OB-GYN);

(iii) Is privileged at a licensed hospital to do hysteroscopies;

(iv) Has successfully completed the manufacturer's training for the device;

(v) Has successfully performed a minimum of twenty hysteroscopies; and

(vi) Has established screening and follow-up protocols for clients being considered for hysteroscopic sterilization.

(12) To become a department-approved provider for hysteroscopic sterilizations, interested providers must send the department the following:

(a) Documentation of successful completion of the manufacturer's training;

(b) Documentation demonstrating privilege at a licensed hospital to perform hysteroscopies;

(c) Documentation attesting to having successfully performed twenty or more hysteroscopies; and

(d) Office protocols for screening and follow-up.

HYSTERECTOMY

(13) Hysterectomies performed for medical reasons may require expedited prior authorization as explained in WAC 388-531-0200(2).

(14) The department reimburses hysterectomy without prior authorization in either of the following circumstances:

(a) The client has been diagnosed with cancer(s) of the female reproductive organs; and/or

(b) The client is forty-six years of age or older.

(15) The department reimburses all attending providers for the hysterectomy procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. If a prior authorization number is necessary for the procedure, it must be on the claim. The department reimburses after the procedure is completed.

[Statutory Authority: RCW 74.08.090. 10-24-071, § 388-531-1550, filed 11/30/10, effective 1/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1650 Substance abuse detoxification physician-related services. (1) The department covers physician services for three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in a department-enrolled hospital-based detoxification center.

(2) The department covers treatment in programs certified under chapter 388-805 WAC or its successor.

(3) The department covers detoxification and medical stabilization services to chemically using pregnant (CUP) women for up to twenty-seven days in an inpatient hospital setting.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1650, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.-057, 74.08.090, and Public Law 104-191. 03-19-081, § 388-531-1650, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1700 Surgical physician-related services. (1) The department's global surgical reimbursement for all covered surgeries includes all of the following:

(a) The operation itself;

(b) Postoperative dressing changes, including:

(i) Local incision care and removal of operative packs;

(ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;

(iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or

(iv) Change and removal of tracheostomy tubes.

(c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) The department's global surgical reimbursement for major surgeries, includes all of the following:

(a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and

(b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) The department's global surgical reimbursement for minor surgeries includes all of the following:

(a) Preoperative visits beginning on the day of surgery; and

(b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, the department does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) The department's global surgical reimbursement for multiple surgical procedures is as follows:

(a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of the department's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of the department's allowed fee for each procedure.

(6) The department allows separate reimbursement for any of the following:

(a) The initial evaluation or consultation;

(b) Preoperative visits more than one day before the surgery;

(c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) The department's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, the department pays the full amount of the procedure with the highest maximum allowable fee.

(d) The department pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus the base diagnostic endoscopy procedure's maximum allowed amount.

(e) The department does not pay when payment for other codes within an endoscopy group is less than the base code.

(8) The department restricts reimbursement for surgery assists to selected procedures as follows:

(a) The department applies multiple surgery reimbursement rules for surgery assists apply. See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) The department bases payment splits between preoperative, intraoperative, and postoperative services on medicare determinations for given surgical procedures or range of procedures. The department pays any procedure that does not have an established medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC 388-531-0450.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1700, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1750 Transplant coverage for physician-related services. The department covers transplants when performed in a department-approved center of excellence. See WAC 388-550-1900 for information regarding transplant coverage.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1750, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(l) The department bases the payment methodology for most physician-related services on medicare's RBRVS. The department obtains information used to update the department's RBRVS from the **MPFSPS.**

(2) The department updates and revises the following RBRVS areas each January prior to the department's annual update.

(3) The department determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a **base period.** Then,

(b) Applying the latest medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels.

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) The department calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, the department establishes maximum allowable fees, also known as "flat" fees.

(i) The department does not use the conversion factor for these codes.

(ii) The department updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at EAC. (See WAC 388-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department of health, the department pays the provider a flat fee only for administering the immunization.

(B) A **cast material maximum allowable fee** is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, the department reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) The department reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The **technical advisory group** reviews RBRVS changes.

(6) The department also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as the department's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, the department applies the increase after calculating budget-neutral fees. The department pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) The department does not allow separate reimbursement for bundled services. However, the department allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

CPT/HCFA MODIFIERS

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for the department to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1850, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1900 Reimbursement—General requirements for physician-related services. (1) The department reimburses physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) In order to be reimbursed, physicians must bill the department according to the conditions of payment under WAC 388-501-0150 and other issuances.

(3) The department does not separately reimburse certain administrative costs or services. The department considers these costs to be included in the reimbursement. These costs and services include the following:

(a) Delinquent payment fees;

(b) Educational supplies;

(c) Mileage;

(d) Missed or canceled appointments;

(e) Reports, client charts, insurance forms, copying expenses;

(f) Service charges;

(g) Take home drugs; and

(h) Telephoning (e.g., for prescription refills).

(4) The department does not routinely pay for procedure codes which have a "#" indicator in the fee schedule. The department reviews these codes for conformance to medicaid program policy only as an exception to policy or as a limitation extension. See WAC 388-501-0160 and 388-501-0165.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-531-1900, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-520. 01-01-012, § 388-531-1900, filed 12/6/00, effective 1/6/01.]

WAC 388-531-2000 Increased payments for physician-related services for qualified trauma cases. (1) The department of social and health services' (DSHS) physician trauma care fund (TCF) is an amount that is legislatively appropriated to DSHS each biennium for the purpose of increasing the department's payment to physicians and other clinicians (those who are performing services within their licensed and credentialed scope of practice) providing qualified trauma care services to medical assistance clients covered under the department's fee-for-service programs.

(2) Trauma care services provided to:

(a) Fee-for-service clients in medicaid, general assistance-unemployable (GAU), alcohol and drug addiction treatment and support act (ADATSA), children's health insurance program (CHIP), and apple health for kids, qualify for enhanced rate payments from the TCF. Trauma care services provided to a GAU or ADATSA client qualify for enhanced rates only during the client's certification period. See WAC 388-416-0010;

(b) Clients in the alien emergency medical and alien medical programs do not qualify for enhanced rate payments from the TCF; and

(c) Clients enrolled in the department's managed care programs do not qualify for enhanced rate payments from the TCF.

(3) To receive payments from the TCF, a physician or other clinician must:

(a) Be on the designated trauma services response team of any department of health (DOH)-designated or DOH-recognized trauma service center;

(b) Meet the provider requirements in this section and other applicable WAC;

(c) Meet the billing requirements in this section and other applicable WAC; and

(d) Submit all information the department requires to monitor the trauma program.

(4) Except as described in subsection (5) of this section and subject to the limitations listed, the department makes payments from the TCF to physicians and other clinicians:

(a) For only those trauma services that are designated by the department as "qualified." Qualified trauma care services include:

(i) Follow-up surgical services provided within six months of the date of the injury. These surgical procedures must have been planned during the initial acute episode of injury; and

(ii) Physiatrist services provided during an inpatient stay immediately following, and within six months of, the initial episode of injury.

(b) For hospital-based services only, and for follow-up surgeries performed in a medicare-certified ambulatory surgery center (ASC). The follow-up surgery must have been performed within six months of the initial traumatic injury.

(c) Only for trauma cases that meet the injury severity score (ISS) (a summary rating system for traumatic anatomic injuries) of:

(i) Thirteen or greater for an adult trauma patient (a client age fifteen or older); or

(ii) Nine or greater for a pediatric trauma patient (a client younger than age fifteen).

(d) On a per-client basis in any DOH-designated or DOH-recognized trauma service center.

(e) At a rate of two and one-half times the department's current fee-for-service rate for qualified trauma services, or other payment enhancement percentage the department determines as appropriate.

(i) The department monitors the payments from the TCF during each state fiscal year (SFY) and makes necessary adjustments to the rate to ensure that total payments from the TCF for the biennium will not exceed the legislative appropriation for that biennium.

(ii) Laboratory and pathology charges are not eligible for payments from the TCF. (See subsection (6)(b) of this section.)

(5) When a trauma case is transferred from one hospital to another, the department makes payments from the TCF to physicians and clinicians, according to the ISS score as follows:

(a) If the transferred case meets or exceeds the appropriate ISS threshold described in subsection (4)(c) of this section, providers who furnish qualified trauma services in either the transferring or receiving facility are eligible for payments from the TCF.

(b) If the transferred case is below the ISS threshold described in subsection (4)(c) of this section, only providers who furnish qualified trauma services in the receiving hospital are eligible for payments from the TCF.

(6) The department makes a TCF payment to a physician or clinician:

(a) Only when the provider submits an eligible trauma claim with the appropriate trauma indicator within the time frames specified by the department; and

(b) On a per-claim basis. Each qualifying trauma service and/or procedure on the provider's claim is paid at the department's current fee-for-service rate, multiplied by the appropriate payment enhancement percentage described in subsection (4)(e) of this section. Laboratory and pathology services and/or procedures are not eligible for payments from the TCF and are paid at the department's current fee-for-service rate.

(7) For purposes of the payments from the TCF to physicians and other clinicians, all of the following apply:

(a) The department considers a request for a claim adjustment submitted by a provider only if the department receives the adjustment request within three hundred sixty-five days from the date of the initial trauma service. At its discretion, and with sufficient public notice, the department may adjust the deadline for submission and/or adjustment of trauma claims in response to budgetary or other program needs;

(b) Except as provided in subsection (7)(a) of this section, the deadline for making adjustments to a trauma claim is the same as the deadline for submitting the initial claim to the department as specified in WAC 388-502-0150(3). See WAC 388-502-0150 (11) and (12) for other time limits applicable to trauma claims;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total payments from the TCF disbursed to providers by the department in a biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions are needed to ensure the department stays within its TCF appropriation (see subsection (4)(e)(i) of this section).

[Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. 10-12-013, § 388-531-2000, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.500, and chapter 43.20A RCW. 08-18-029, § 388-531-2000, filed 8/27/08, effective 9/27/08. Statutory Authority: RCW 74.08.090, 74.09.500. 05-20-050, § 388-531-2000, filed 9/30/05, effective 10/31/05; 04-19-113, § 388-531-2000, filed 9/21/04, effective 10/22/04.]

Chapter 388-532 WAC

REPRODUCTIVE HEALTH/FAMILY PLANNING ONLY/TAKE CHARGE

WAC

388-532-730 TAKE CHARGE program—Provider requirements.
388-532-760 TAKE CHARGE program—Documentation requirements.

WAC 388-532-730 TAKE CHARGE program—Provider requirements. (1) A TAKE CHARGE provider must:

(a) Be a department-approved family planning provider as described in WAC 388-532-050;

(b) Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to the department's TAKE CHARGE program guidelines;

(c) Participate in the department's specialized training for the TAKE CHARGE demonstration and research program prior to providing TAKE CHARGE services. Providers must document that each individual responsible for providing TAKE CHARGE services is trained on all aspects of the TAKE CHARGE program;

(d) Comply with the required general department and TAKE CHARGE provider policies, procedures, and administrative practices as detailed in the department's billing instructions and provide referral information to clients regarding available and affordable nonfamily planning primary care services;

(e) If requested by the department, participate in the research and evaluation component of the TAKE CHARGE demonstration and research program.

(f) Forward the client's services card and TAKE CHARGE brochure to the client within seven working days of receipt unless otherwise requested in writing by the client;

(g) Inform the client of his or her right to seek services from any TAKE CHARGE provider within the state; and

(h) Refer the client to available and affordable nonfamily planning primary care services, as needed.

(2) Department providers (e.g., pharmacies, laboratories, surgeons performing sterilization procedures) who are not TAKE CHARGE providers may furnish family planning ancillary TAKE CHARGE services, as defined in this chapter, to eligible TAKE CHARGE clients. The department reimburses for these services under the rules and fee schedules applicable to the specific services provided under the department's other programs.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-532-730, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-730, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-730, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-730, filed 10/8/02, effective 11/8/02.]

WAC 388-532-760 TAKE CHARGE program—Documentation requirements. In addition to the documentation requirements in WAC 388-502-0020, TAKE CHARGE providers must keep the following records:

(1) TAKE CHARGE application form(s);

(2) Signed supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE program;

(3) Documentation of the department's specialized TAKE CHARGE training and/or in-house in-service TAKE CHARGE training for each individual responsible for providing TAKE CHARGE.

(4) Chart notes that reflect the primary focus and diagnosis of the visit was family planning;

(5) Contraceptive methods discussed with the client;

(6) Notes on any discussions of emergency contraception and needed prescription(s);

(7) The client's plan for the contraceptive method to be used, or the reason for no contraceptive method and plan;

(8) Documentation of the education, counseling and risk reduction (ECRR) service, if provided, with sufficient detail that allows for follow-up;

(9) Documentation of referrals to or from other providers;

(10) A form signed by the client authorizing release of information for referral purposes, as necessary;

(11) The client's written and signed consent requesting that his or her services card be sent to the TAKE CHARGE provider's office to protect confidentiality;

(12) A copy of the client's picture identification;

(13) A copy of the documentation used to establish United States citizenship or legal permanent residency; and

(14) If applicable, a copy of the completed department sterilization consent form (DSHS 13-364 - available for download at http://www.dshs.wa.gov/msa/forms/eforms.html) (see WAC 388-531-1550).

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-532-760, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-760, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-760, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-760, filed 10/8/02, effective 11/8/02.]

Chapter 388-533 WAC
MATERNITY-RELATED SERVICES

WAC

388-533-0300 Services under First Steps.
388-533-0310 Maternity support services—Purpose.
388-533-0315 Maternity support services—Definitions.
388-533-0320 Maternity support services—Client eligibility.
388-533-0325 Maternity support services—Provider requirements.
388-533-0330 Maternity support services—Covered services.
388-533-0340 Maternity support services—Noncovered services.
388-533-0345 Maternity support services—Payment.
388-533-0360 Infant case management—Purpose.
388-533-0365 Infant case management—Definitions.
388-533-0370 Infant case management—Eligibility.
388-533-0375 Infant case management—Provider requirements.
388-533-0380 Infant case management—Covered services.
388-533-0385 Infant case management—Noncovered services.
388-533-0386 Infant case management—Payment.

WAC 388-533-0300 Services under First Steps. (1) Under the 1989 Maternity Care Access Act, and RCW 74.09.760 through 74.09.910, the department established First Steps to provide access to services for eligible women and their infants.

(2) The rules for the:

(a) Maternity support services (MSS) component of First Steps are found in WAC 388-533-0310 through 388-533-0345.

(b) Infant case management (ICM) component of First Steps are found in WAC 388-533-0360 through 388-533-0386.

(c) Childbirth education (CBE) component of First Steps are found in WAC 388-533-0390.

(3) Other services under First Steps include:

(a) Medical services, including full medical coverage, prenatal care, delivery, post-pregnancy follow-up, dental, vision, and twelve months family planning services post-pregnancy;

(b) Ancillary services, including but not limited to, expedited medical eligibility determination, case finding and outreach; and

(c) Alcohol and drug assessment and treatment services for pregnant women available statewide and administered by the division of behavioral health and recovery (see WAC 388-533-0701).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0300, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0300, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 74.09.770, and 74.09.800. 00-14-068, § 388-533-0300, filed 7/5/00, effective 8/5/00.]

WAC 388-533-0310 Maternity support services—Purpose. The purpose of maternity support services (MSS) is to:

(1) Improve and promote healthy birth outcomes. Services are delivered by an MSS interdisciplinary team to eligible pregnant and post-pregnant women and their infants.

(2) Help eligible clients to access:

(a) Prenatal care as early in the pregnancy as possible; and

(b) Healthcare for their infants.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0310, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0310, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0315 Maternity support services—Definitions. The following definitions and those found in WAC 388-500-0005 apply to maternity support services (MSS) and infant case management (ICM) (see WAC 388-533-0360 through 388-533-0386 for ICM rules).

"Basic health messages"—For the purposes of MSS, means the preventive health education messages designed to promote healthy pregnancies, healthy newborns and healthy parenting during the first year of life.

"Care coordination"—Professional collaboration and communication between the client's MSS provider and other medical and/or health and social services providers to address the individual client's needs as identified in the care plan.

"Care plan"—A written plan that must be developed and maintained throughout the eligibility period for each client in MSS and ICM.

"Case management"—Services to assist individuals to gain access to needed medical, social, educational, and other services.

"Childbirth education (CBE)"—Established as a component of the First Steps program to provide educational sessions offered in a group setting that prepares a pregnant woman and her support person(s) for an upcoming childbirth and healthy parenting.

"Department of health (DOH)"—The state agency that works to protect and improve the health of people in Washington state.

"Department of social and health services (department)"—The state agency that administers social and health services programs for Washington state.

"First Steps"—The program created under the 1989 Maternity Care Access Act.

"Infant case management (ICM)"—Established as a component of the First Steps program to provide parent(s) with information and assistance in accessing needed medical, social, educational, and other services to improve the welfare of infants.

"Infant case management (ICM) screening"—A brief in-person evaluation provided by a qualified person to determine whether an infant and the infant's parent(s) have a specific risk factor(s).

"Linking"—Assisting clients to identify and use community resources to address specific medical, social and educational needs.

"Maternity cycle"—An eligibility period for maternity support services that begins during pregnancy and continues to the end of the month in which the sixtieth-day post-pregnancy occurs.

"Maternity support services (MSS)"—Established as a component of the First Steps program to provide screening, assessment, basic health messages, education, counseling, case management, care coordination, and other interventions delivered by an MSS interdisciplinary team during the maternity cycle.

"Maternity support services (MSS) interdisciplinary team"—A group of providers consisting of at least a community health nurse, a certified registered dietitian, a behavioral health specialist, and, at the discretion of the First Steps agency, a community health worker, who work together and communicate frequently to share specialized knowledge, skills, and experience in order to address risk factors identified in a client's care plan. Based upon individual client need, each team member must be available to provide maternity support services and consultation.

"Parent(s)"—A person who resides with an infant and provides the infant's day-to-day care, and is:

- The infant's natural or adoptive parent(s);
- A person other than a foster parent who has been granted legal custody of the infant; or
- A person who is legally obligated to support the infant.

"Risk factors"—The biopsychosocial factors that could lead to poor birth outcomes, infant morbidity, and/or infant mortality.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0315, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0315, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0320 Maternity support services—Client eligibility. (1) To receive maternity support services (MSS), a client must:

(a) Be covered under one of the following medical assistance programs:

(i) Categorically needy program (CNP);

(ii) CNP—Children's health insurance program;

(iii) Medically needy program (MNP); or

(iv) A pregnancy medical program as described in WAC 388-462-0015.

(b) Be within the eligibility period of a maternity cycle as defined in WAC 388-533-0315; and

(c) Meet any other eligibility criteria as determined by the department and published in the department's current billing instructions and/or numbered memoranda.

(2) Clients who meet the eligibility criteria in this section may receive:

(a) An in-person screening by a provider who meets the criteria established in WAC 388-533-0325. Clients are screened for risk factors related to issues that may impact their birth outcomes.

(b) Up to the maximum number of MSS units of service allowed per client as determined by the department and published in the department's current billing instructions and/or numbered memoranda. The department may determine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment of maternity support services for any specific biennium.

(3) Clients meeting the eligibility criteria in this section who are enrolled in a department-contracted managed care plan, are eligible for MSS outside their plan.

(4) See chapter 388-534 WAC for clients eligible for coverage under the early periodic screening, diagnosis and treatment (EPSDT) program.

(5) Clients receiving MSS before July 1, 2009, are subject to the transition plan as determined and published by the department in numbered memoranda.

(6) Clients who do not agree with a department decision regarding eligibility for MSS have a right to a fair hearing under chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0320, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0320, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0325 Maternity support services—Provider requirements. (1) To be paid for providing maternity support services (MSS) and infant case management (ICM) services to eligible clients, an agency or entity must:

(a) Be currently approved as an MSS/ICM provider by the department of health (DOH);

(b) Be enrolled as an eligible provider with the department of social and health services' (department's) health and recovery services administration (HRSA)(see WAC 388-502-0010);

(c) Ensure that staff providing services meet the minimum regulatory and educational qualifications for the scope of services provided; and

(d) Meet the requirements in this chapter, chapter 388-502 WAC and the department's current published billing instructions and numbered memoranda.

(2) An individual or service organization that has a written agreement with an agency or entity that meets the requirements in subsection (1) of this section may also provide MSS and ICM services to eligible clients.

(a) The department requires the agency or entity to:

(i) Keep a copy of the written agreement on file;

(ii) Ensure that an individual or service organization staff member providing MSS/ICM services meets the minimum regulatory and educational qualifications required of an MSS/ICM provider;

(iii) Assure that the individual or service organization provides MSS/ICM services under the requirements of this chapter; and

(iv) Maintain professional, financial, and administrative responsibility for the individual or service organization.

(b) The agency or entity is responsible to:

(i) Bill for services using the agency's or entity's assigned provider number; and

(ii) Reimburse the individual or service organization for MSS/ICM services provided under the written agreement.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0325, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0325, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0330 Maternity support services—Covered services. (1) The department covers maternity support services (MSS) provided by an MSS interdisciplinary team, subject to the restrictions and limitations in this section and other applicable WAC.

(2) Covered services include:

(a) In-person screening(s) for risk factors related to pregnancy and birth outcomes;

(b) Brief assessment when indicated;

(c) Education that relates to improving pregnancy and parenting outcomes;

(d) Interventions for risk factors identified on the care plan;

(e) Basic health messages;

(f) Case management services;

(g) Care coordination;

(h) Family planning screening and referral;

(i) Screening and referral for tobacco usage and/or exposure;

(j) Infant case management (ICM) screening; and

(k) Additional services as determined and published in the maternity support services/infant case management (MSS/ICM) billing instructions.

(3) The department pays for covered maternity support services according to WAC 388-533-0345.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0330, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0330, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0340 Maternity support services—Noncovered services. (1) The department covers only those services that are listed in WAC 388-533-0330.

(2) The department evaluates a request for any noncovered service under the provisions of WAC 388-501-0160. When early periodic screening, diagnosis and treatment (EPSDT) applies, the department evaluates a request for a noncovered service according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see chapter 388-534 WAC for EPSDT rules).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0340, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-533-0340, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0340, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0345 Maternity support services—Payment. The department pays for the covered maternity support services (MSS) described in WAC 388-533-0330 on a fee-for-service basis subject to the following:

(1) MSS must be:

(a) Provided to a client who meets the eligibility requirements in WAC 388-533-0320;

(b) Provided to a client on an individual basis in a face-to-face encounter;

(c) Provided by an agency or entity that meets the criteria established in WAC 388-533-0325;

(d) Provided according to the department's current published maternity support services/infant case management (MSS/ICM) billing instructions and/or numbered memoranda;

(e) Documented in the client's record or chart; and

(f) Billed using:

(i) The eligible client's department-assigned client identification number;

(ii) The appropriate procedure codes and modifiers identified in the department's current published MSS/ICM billing instructions and/or numbered memoranda; and

(iii) The agency's department-assigned MSS/ICM provider number. The department pays the agency or entity for providing MSS to eligible clients, not the individual or service organization that has a written agreement with the agency to provide MSS.

(2) The department:

(a) Pays MSS in units of time with one unit being equal to fifteen minutes of one-to-one service delivered face-to-face;

(b) When directed by the legislature to achieve targeted expenditure levels for payment of maternity support services for any specific biennium, may determine the maximum number of units allowed per client; and

(c) Publishes the maximum number of units allowed per client in the MSS/ICM billing instructions and/or numbered memoranda.

(3) For a client enrolled in a managed care plan who is eligible to receive MSS, the department pays for MSS:

(a) Delivered outside the plan on a fee-for-service basis as described in this section; and

(b) Subject to the same program rules that apply to a client who is not enrolled in a managed care plan.

(4) Limitation extension requests to exceed the number of allowed MSS units of service may be authorized according to WAC 388-501-0169.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-011, § 388-533-0345, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0345, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0360 Infant case management—Purpose. The purpose of infant case management (ICM) is to improve the welfare of infants by providing their parent(s) with information and assistance in order to access needed medical, social, educational, and other services (SSA 1915(g)).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-010, § 388-533-0360, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0360, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0365 Infant case management—Definitions. The definitions in WAC 388-533-0315, Maternity support services definitions, also apply to infant case management (ICM).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-010, § 388-533-0365, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0365, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0370 Infant case management—Eligibility. (1) To receive infant case management (ICM), an infant must:

(a) Be covered under one of the medical assistance programs listed in WAC 388-533-0320(1);

(b) Meet the age requirement for ICM which is the day after the maternity cycle (defined in WAC 388-533-0315) ends, through the last day of the month of the infant's first birthday;

(c) Reside with at least one parent (see WAC 388-533-0315 for definition of parent);

(d) Have a parent(s) who needs assistance in accessing medical, social, educational and/or other services to meet the infant's basic health and safety needs; and

(e) Not be receiving any case management services funded through Title XIX medicaid that duplicate ICM services.

(2) Infants who meet the eligibility criteria in subsection (1) of this section, and the infant's parent(s), are eligible to receive:

(a) An in-person screening by a provider who meets the criteria established in WAC 388-533-0375. Infants and their parent(s) are screened for risk factors related to issues that may impact the infant's welfare, health, and/or safety.

(b) Up to the maximum number of ICM units of service allowed per client as determined by the department and published in the department's current billing instructions and/or numbered memoranda. The department may determine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment in any specific biennium.

(3) Clients meeting the eligibility criteria in subsection (1) of this section who are enrolled in a department-contracted managed care plan are eligible for ICM services outside their plan.

(4) See chapter 388-534 WAC for clients eligible for coverage under the early periodic screening, diagnosis and treatment (EPSDT) program.

(5) Clients receiving ICM before July 1, 2009, are subject to the transition plan as determined and published by the department in numbered memoranda.

(6) Clients who do not agree with a department decision regarding eligibility for ICM have a right to a fair hearing under chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-010, § 388-533-0370, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0370, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0375 Infant case management—Provider requirements. Infant case management (ICM) services can be provided only by a qualified person who is employed by an agency or entity that meets the requirements in WAC 388-533-0325. Additionally, to qualify as an ICM provider, the person must meet at least one of the following:

(1) Be a current member of the maternity support services (MSS) interdisciplinary team;

(2) Have a bachelor of arts, bachelor of science, or higher degree, plus at least one year of full-time experience working in one or more of the following areas:

(a) Community social services;

(b) Public health services;

(c) Crisis intervention;

(d) Outreach and referral programs; or

(e) Other social services-related fields.

(3) Have an associate of arts degree, or an associate's degree in a closely allied field, plus at least two years of full-time experience in an area listed in (1) of this section. In addition, at least once per calendar month, the department requires a provider qualifying under this subsection to be under the supervision of a clinical staff person who meets the criteria in (1) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-010, § 388-533-0375, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0375, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0380 Infant case management—Covered services. (1) The department covers infant case management (ICM) services subject to the restrictions and limitations in this section and other applicable WAC.

(2) Covered services include:

(a) An initial in-person screening for ICM services which includes an assessment of risk factors, and the development of an individualized care plan;

(b) Case management services and care coordination;

(c) Linking and referring the infant and parent(s) to other services or resources;

(d) Advocating for the infant and parent(s);

(e) Follow-up contact(s) with the parent(s) to ensure the care plan continues to meet the needs of the infant and parent(s); and

(f) Additional services as determined and published in the maternity support services/infant case management (MSS/ICM) billing instructions.

(3) The department pays for covered ICM services according to WAC 388-533-0386.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-010, § 388-533-0380, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0380, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0385 Infant case management—Noncovered services. (1) The department covers only those services that are listed in WAC 388-533-0380.

(2) The department evaluates a request for any noncovered service under the provisions of WAC 388-501-0160. When early periodic screening, diagnosis and treatment (EPSDT) applies, the department evaluates a request for a noncovered service according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see chapter 388-534 WAC for EPSDT rules).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-010, § 388-533-0385, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-533-0385, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0385, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0386 Infant case management—Payment. The department pays for the covered infant case management (ICM) services described in WAC 388-533-0380 on a fee-for-service basis subject to the following.

(1) ICM services must be:

(a) Provided to a client who meets the eligibility requirements in WAC 388-533-0370;

(b) Provided by a person who meets the criteria established in WAC 388-533-0375;

(c) Provided according to the department's current published maternity support services/infant case management (MSS/ICM) billing instructions and/or numbered memoranda;

(d) Documented in the infant's and/or infant's parent(s) record or chart; and

(e) Billed using:

(i) The eligible infant's department-assigned client identification number;

(ii) The appropriate procedure codes and modifiers identified in the department's current published MSS/ICM billing instructions and/or numbered memoranda; and

(iii) The department-assigned MSS/ICM provider number.

(2) The department:

(a) Pays ICM services in units of time with one unit being equal to fifteen minutes of one-to-one service delivered face-to-face;

(b) When directed by the legislature to achieve targeted expenditure levels for payment of maternity support services for any specific biennium, may determine the maximum number of units allowed per client; and

(c) Publishes the maximum number of units allowed per client in the MSS/ICM billing instructions and/or numbered memoranda.

(3) For a client enrolled in a managed care plan who is eligible to receive ICM, the department pays ICM services:

(a) Delivered outside the plan on a fee-for-service basis as described in this section; and

(b) Subject to the same program rules that apply to a client who is not enrolled in a managed care plan.

(4) Limitation extension requests to exceed the number of allowed ICM units of service may be authorized according to WAC 388-501-0169.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910, and 2009 c 564 § 1109. 10-12-010, § 388-533-0386, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.-910. 04-13-049, § 388-533-0386, filed 6/10/04, effective 7/11/04.]

Chapter 388-534 WAC

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

WAC

388-534-0200 Enhanced payments for EPSDT screens for children in out-of-home placement.

WAC 388-534-0200 Enhanced payments for EPSDT screens for children in out-of-home placement. The department reimburses providers an enhanced fee for EPSDT screens provided to children in out-of-home placement. See the department's EPSDT billing instructions for specific billing code requirements and the fee.

(1) For the purposes of this section, out-of-home placement is defined as twenty-four hour per day, temporary, substitute care for a child:

(a) Placed away from the child's parents or guardians in licensed, paid, out-of-home care; and

(b) For whom the department or a licensed or certified child placing agency has placement and care responsibility.

(2) The department pays an enhanced fee to the providers listed in subsection (3) of this section for EPSDT screens provided to only those children in out-of-home placement.

(3) The following providers are eligible to perform EPSDT screens and bill the enhanced rate for children in out-of-home placement:

(a) EPSDT clinics;

(b) Physicians;

(c) Advanced registered nurse practitioners (ARNPs);

(d) Physician assistants (PAs) working under the guidance of a physician;

(e) Nurses specially trained through the department of health (DOH) to perform EPSDT screens; and

(f) Registered nurses working under the guidance of a physician or ARNP.

(4) In order to be paid an enhanced fee, services furnished by the providers listed in subsection (3) of this section must meet the federal requirements for EPSDT screens at 42 CFR Part 441 Subpart B, which were in effect as of December 1, 2001.

(5) The provider must retain documentation of the EPSDT screens in the client's medical file. The provider must use the department's Well Child Exam forms or provide equivalent information. The Well Child Exam forms include the required elements for an EPSDT screen. The Well Child Exam forms (DSHS 13-683A through 13-686B) are available for downloading at no charge at http://www1.dshs.wa.gov/msa/forms/eforms.html.

(6) The department conducts evaluations of client files and payments made under this program. The department may recover the enhanced payment amount when:

(a) The client was not in out-of-home placement as defined in subsection (1) of this section when the EPSDT screen was provided; or

(b) Documentation was not in the client's medical file (see subsection (5) of this section).

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-534-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 42 C.F.R., Part 441, Subpart B. 02-07-016, § 388-534-0200, filed 3/8/02, effective 4/8/02.]

Chapter 388-539 WAC
HIV/AIDS RELATED SERVICES

WAC

388-539-0200 AIDS—Health insurance premium payment program.
388-539-0300 Case management for persons living with HIV/AIDS.
388-539-0350 HIV/AIDS case management reimbursement information.

WAC 388-539-0200 AIDS—Health insurance premium payment program. (1) The purpose of the AIDS health insurance premium payment program is to help individuals who are not eligible for the department's medical programs and who are diagnosed with AIDS, pay their health insurance premiums.

(2) To be eligible for the AIDS health insurance premium payment program, individuals must:

(a) Be diagnosed with AIDS as defined in WAC 246-100-011;

(b) Be a resident of the state of Washington;

(c) Be responsible for all, or part of, the health insurance premium payment (without the department's help);

(d) Not be eligible for one of the department's other medical programs;

(e) Not have personal income that exceeds three hundred seventy percent of the federal poverty level; and

(f) Not have personal assets, after exemptions, exceeding fifteen thousand dollars. The following personal assets are exempt from the personal assets calculation:

(i) A home used as the person's primary residence; and

(ii) A vehicle used as personal transportation.

(3) The department may contract with a not-for-profit community agency to administer the AIDS health insurance premium payment program. The department or its contractor determines an individual's initial eligibility and redetermines eligibility on a periodic basis. To be eligible, individuals must:

(a) Cooperate with the department's contractor;

(b) Cooperate with eligibility determination and redetermination process; and

(c) Initially meet and continue to meet the eligibility criteria in subsection (2) of this section.

(4) Individuals, diagnosed with AIDS, who are eligible for one of the department's medical programs may ask the department to pay their health insurance premiums under a separate process. The client's community services office (CSO) is able to assist the client with this process.

(5) Once an individual is eligible to participate in the AIDS health insurance premium payment program, eligibility would cease only when one of the following occurs. The individual:

(a) Is deceased;

(b) Voluntarily quits the program;

(c) No longer meets the requirements of subsection (2) of this section; or

(d) Has benefits terminated due to the legislature's termination of the funding for this program.

(6) The department sets a reasonable payment limit for health insurance premiums. The department sets its limit by tracking the charges billed to the department for department clients who have AIDS. The department does not pay health insurance premiums that exceed fifty percent of the average of charges billed to the department for its clients with AIDS.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-539-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.757. 00-14-070, § 388-539-0200, filed 7/5/00, effective 8/5/00.]

WAC 388-539-0300 Case management for persons living with HIV/AIDS. The department provides HIV/AIDS case management to assist persons infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for department reimbursed HIV/AIDS case management services, the person must:

(a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring as provided in WAC 388-539-0350(2).

(2) The department has an interagency agreement with the Washington state department of health (DOH) to administer the HIV/AIDS case management program for the department's Title XIX (medicaid) clients.

(3) HIV/AIDS case management agencies who serve the department's clients must be approved to perform these services by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive persons of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current client-signed authorization to release/obtain information form. The provider must have a valid authorization on file for the months that case management services are billed to the department (see RCW 70.02.-030). The fee referenced in RCW 70.02.030 is included in the department's reimbursement to providers. The department's clients may not be charged for services or documents related to covered services.

(c) Maintain sufficient contact to ensure the effectiveness of ongoing services per subsection (5) of this section. The department requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individual service plan (ISP).

(5) HIV/AIDS case management providers must document services as follows:

(a) Providers must initiate a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services. Providers must complete the assessment before billing for ongoing case management services. If the assessment does not meet these requirements, the provider must document the reason(s) for failure to do so. The assessment must include the following elements as reported by the client:

(i) Demographic information (e.g., age, gender, education, family composition, housing.);

(ii) Physical status, the identity of the client's primary care provider, and current information on the client's medications/treatments;

(iii) HIV diagnosis (both the documented diagnosis at the time of assessment and historical diagnosis information);

(iv) Psychological/social/cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems (e.g., family, friends and spiritual support);

(ix) Legal status, durable power of attorney, and any self-reported criminal history; and

(x) Self-reported behaviors which could lead to HIV transmission or re-infection (e.g., drug/alcohol use).

(b) Providers must develop, monitor, and revise the client's individual service plan (ISP). The ISP identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving the department reimbursed HIV/AIDS case management services; and

(ii) Reviewed monthly by the case manager through in-person or telephone contact with the client. Both the review and any changes must be noted by the case manager:

(A) In the case record narrative; or

(B) By entering notations in, initialing and dating the ISP.

(c) Maintained ongoing narrative records - These records must document case management services provided in each month for which the provider bills the department. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-539-0300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0300, filed 11/16/00, effective 12/17/00.]

WAC 388-539-0350 HIV/AIDS case management reimbursement information. (1) The department reimburses HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment—The assessment must cover the areas outlined in WAC 388-539-0300 (1) and (5).

(i) The department reimburses only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) The department reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is medicaid eligible and the ongoing case management has been provided.

(b) HIV/AIDS case management, full-month—Providers may request the full-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. The department reimburses only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month—Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reimbursement, the department may reimburse two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) The department limits reimbursement to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. The depart-

ment limits reimbursement for monitoring to ninety days past the time the last active service element of the ISP is completed. Case management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill the department for up to ninety days of monitoring:

(a) Document the client's history of recurring need;

(b) Assess the client for possible future instability; and

(c) Provide monthly monitoring contacts.

(3) The department reinstates reimbursement for ongoing case management if a client shifts from monitoring status to active case management status due to documented need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-539-0350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0350, filed 11/16/00, effective 12/17/00.]

Chapter 388-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

WAC

388-543-1150	Limits and limitation extensions.
388-543-1300	Equipment, related supplies, or other nonmedical supplies, and devices that are not covered.
388-543-1600	Items and services which require prior authorization.
388-543-2800	Reusable and disposable medical supplies.

WAC 388-543-1150 Limits and limitation extensions. The department covers non-DME (MSE), DME, and related supplies, prosthetics, orthotics, medical supplies, and related services as described in WAC 388-543-1100(1). The department limits the amount, frequency, or duration of certain covered MSE, DME, and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client. In order to exceed the stated limits, the provider must request a limitation extension (LE), which is a form of prior authorization (PA). The department evaluates such requests for LE under the provisions of WAC 388-501-0169. Procedures for LE are found in department billing instructions. The following items and quantities do not require prior authorization; requests to exceed the stated quantities require LE:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - one pint per month;

(b) Alcohol wipes (box of two hundred) - one box per month;

(c) Betadine or pHisoHex solution - one pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - one box per month; or

(e) Periwash (when soap and water are medically contraindicated) - one five-ounce bottle of concentrate solution per six-month period.

(2) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - one in a three-month period;

(b) Spring-powered device for lancet - one in a six-month period.

(c) Test strips and lancets for an insulin dependent diabetic - one hundred of each, per month; and

(d) Test strips and lancets for a noninsulin dependent diabetic - one hundred of each, per three-month period.

(3) Braces, belts and supportive devices:

(a) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - two per twelve-month period;

(b) Ankle, elbow, or wrist brace - two per twelve-month period;

(c) Lumbosacral brace, rib belt, or hernia belt - one per twelve-month period;

(d) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - one per twelve-month period.

(4) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - one per twelve-month period;

(b) Synthetic or lambs wool sheepskin pad - one per twelve-month period;

(c) Heel or elbow protectors - four per twelve-month period.

(5) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - ten per month.

(c) Adhesive remover or solvent - three ounces per month.

(d) Adhesive remover wipes, fifty per box - one box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - ten per month.

(g) Continent plug for continent stoma - thirty per month.

(h) Continent device for continent stoma - one per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - ten per month.

(m) Irrigation bag - two every six months.

(n) Irrigation cone and catheter, including brush - two every six months.

(o) Irrigation supply, sleeve - one per month.

(p) Ostomy belt (adjustable) for appliance - two every six months.

(q) Ostomy convex insert - ten per month.

(r) Ostomy ring - ten per month.

(s) Stoma cap - thirty per month.

(t) Ostomy faceplate - ten per month. The department does not allow the following to be used on a faceplate in combination with drainable pouches (refer to the billing instructions for further details):

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(6) Urological supplies - diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a backsheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a topsheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the backsheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a backsheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) The department covers the products in this subsection only when they are used alone; they cannot be used in combination with each other. The department approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use (see department billing instructions for how to specify this when billing). The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit (see subsections (g), (h), (i), (j), (k), (l), and (m) of this section for product limitations). The following products cannot be used together:

(i) Disposable diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) Purchased disposable diapers (any size) are limited to:

(i) Two hundred per month for a child three to eighteen years of age; and

(ii) Two hundred per month for an adult nineteen years of age and older.

(h) Reusable cloth diapers (any size) are limited to:

(i) Purchased - thirty-six per year; and

(ii) Rented - two hundred per month.

(i) Disposable briefs and pull-up pants (any size) are limited to:

(i) Two hundred per month for a child age three to eighteen years of age; and

(ii) One hundred fifty per month for an adult nineteen years of age and older.

(j) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - four per year.

(ii) Rented - one hundred fifty per month.

(k) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred per month.

(l) Underpads for beds are limited to:

(i) Disposable (any size) - one hundred eighty per month.

(ii) Purchased, reusable (large) - forty-two per year.

(iii) Rented, reusable (large) - ninety per month.

(7) Urological supplies - urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - two per month. This cannot be billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. This cannot be billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - two per twelve-month period.

(e) Indwelling catheters (any type) - three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - one hundred and twenty per month. These cannot be billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - three per month. These cannot be billed in combination with: Other insertion trays without drainage bag and/or indwelling catheter; individual indwelling catheters; and/or individual lubricant packets.

(g) Intermittent urinary catheter - one hundred twenty per month. These cannot be billed in combination with: An insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston) - cannot be billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - thirty per month. These cannot be billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - thirty per month. These cannot be billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric). Allowed as replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - two per month. This cannot be billed in combination with: a latex urinary leg bag; urinary suspensory without leg bag; extension drainage tubing; or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - two per month.

(o) Urinary leg bag, vinyl, with or without tube - two per month. This cannot be billed in combination with: A leg strap; or an insertion tray with drainage bag and without catheter.

(p) Urinary leg bag, latex - one per month. This cannot be billed in combination with an insertion tray with drainage bag and with or without catheter.

(8) Miscellaneous supplies:

(a) Bilirubin light therapy supplies - five days' supply. The department reimburses only when these are provided with a prior authorized bilirubin light.

(b) Continuous passive motion (CPM) softgoods kit - one, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - one box of twenty.

(d) Eye patch (adhesive wound cover) - one box of twenty.

(e) Nontoxic gel (e.g., LiceOut TM) for use with lice combs - one bottle per twelve month period.

(f) Nonsterile gloves - one hundred per box, two box per month.

(g) Sterile gloves - thirty pair, per month.

(9) Miscellaneous DME:

(a) Bilirubin light or light pad - five days rental per twelve-month period.

(b) Blood glucose monitor (specialized or home) - one in a three-year period.

(c) Continuous passive motion (CPM) machine - up to ten days rental and requires prior authorization.

(d) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - two per twelve-month period.

(e) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap w/adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - two per twelve-month period.

(f) Pneumatic compressor - one in a five-year period.

(g) Positioning car seat - one in a five-year period.

(10) Prosthetics and orthotics:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - one every five years.

(b) Preparatory, above knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, molded to model - one per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - one per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - one per twelve-month period.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - one per twelve-month period.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(11) Positioning devices:

(a) Positioning system/supine boards (small or large), including padding, straps adjustable armrests, footboard, and support blocks - one in a five-year period.

(b) Prone stander (child, youth, infant or adult size) - one in a five-year period.

(c) Adjustable standing frame (for child/adult thirty - sixty-eight inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor, and a pair of foot blocks - one in a five-year period.

(12) Beds, mattresses, and related equipment:

(a) Pressure pad, alternating with pump - one in a five-year period.

(b) Dry pressure mattress - one in a five-year period.

(c) Gel or gel-like pressure pad for mattress - one in a five-year period.

(d) Gel pressure mattress - one in a five-year period.

(e) Water pressure pad for mattress - one in a five-year period.

(f) Dry pressure pad for mattress - one in a five-year period.

(g) Mattress, inner spring - one in a five-year period.

(h) Mattress, foam rubber - one in a five-year period.

(i) Hospital bed, semi-electric - one in a ten-year period.

(j) Bedside rails - one in a ten-year period.

(13) Other patient room equipment:

(a) Patient lift, hydraulic, with seat or sling - one in a five-year period.

(b) Traction equipment - one in a five year period.

(c) Trapeze bars - one in a five-year period.

(d) Fracture frames - one in a five-year period.

(e) Transfer board or devices - one in a five-year period.

(14) Noninvasive bone growth stimulators (such as osteogenesis stimulators) - one in a five-year period.

(15) Communication devices - artificial larynx, any type - one in a five-year period.

(16) Ambulatory aids:

(a) Canes - one in a five-year period.

(b) Crutches - one in a five-year period.

(c) Walkers - one in a five-year period.

[Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. 10-13-167, § 388-543-1150, filed 6/23/10, effective 7/24/10. Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090. 09-22-047, § 388-543-1150, filed 10/28/09, effective 11/28/09. Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1150, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-543-1150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-1150, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.-090, and Public Law 104-191. 03-19-082, § 388-543-1150, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-1150, filed 7/31/01, effective 8/31/01.]

WAC 388-543-1300 Equipment, related supplies, or other nonmedical supplies, and devices that are not covered. (1) The department pays only for DME and related supplies, medical supplies and related services that are medically necessary, listed as covered in this chapter, and meet the definition of DME and medical supplies as defined in WAC 388-543-1000 and prescribed per WAC 388-543-1100 and 388-543-1200.

(2) The department pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS) that meet the definition of prosthetic and orthotic as defined in WAC 388-543-1000 and are prescribed per WAC 388-543-1100 and 388-543-1200.

(3) The department considers all requests for covered DME, related supplies and services, medical supplies, prosthetics, orthotics, and related services under the provisions of WAC 388-501-0165.

(4) The department evaluates a request for any DME item listed as noncovered in this chapter under the provisions of WAC 388-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the department evaluates a noncovered service, equipment, or supply according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-543-0100 for EPSDT rules).

(5) The department specifically excludes services and equipment in this chapter from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

(a) Included as part of a managed care plan service package;

(b) Included in a waivered program;

(c) Part of one of the medicare programs for qualified medicare beneficiaries; or

(d) Requested for a child who is eligible for services under the EPSDT program. The department reviews these requests according to the provisions of chapter 388-534 WAC.

(6) Excluded services and equipment include, but are not limited to:

(a) Services, procedures, treatment, devices, drugs, or the application of associated services that the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the services are provided;

(b) Any service specifically excluded by statute;

(c) A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by the department for the client contributes to an increased utility bill (refer to the aging and disability services administration's (ADSA) COPES program for potential coverage);

(d) Hairpieces or wigs;

(e) Material or services covered under manufacturers' warranties;

(f) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(g) Outpatient office visit supplies, such as tongue depressors and surgical gloves;

(h) Prosthetic devices dispensed solely for cosmetic reasons;

(i) Home improvements and structural modifications, including but not limited to the following:

(i) Automatic door openers for the house or garage;

(ii) Saunas;

(iii) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(iv) Swimming pools;

(v) Whirlpool systems, such as jacuzzies, hot tubs, or spas; or

(vi) Electrical rewiring for any reason;

(vii) Elevator systems and elevators; and

(viii) Lifts or ramps for the home; or

(ix) Installation of bathtubs or shower stalls.

(j) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(i) Back-packs, pouches, bags, baskets, or other carrying containers;

(ii) Bed boards/conversion kits, and blanket lifters (e.g., for feet);

(iii) Car seats for children under five, except for positioning car seats that are prior authorized. Refer to WAC 388-543-1700(13) for car seats;

(iv) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(v) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(vi) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(A) Devices intended for amplifying voices (e.g., microphones);

(B) Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to ADSA COPES or outpatient hospital programs for emergency response systems and services);

(C) Two-way radios; and

(D) Rental of related equipment or services;

(vii) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads, and light boxes;

(viii) Ergonomic equipment;

(ix) Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, trampolines;

(x) Generators;

(xi) Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards);

(xii) Computer utility bills, telephone bills, internet service, or technical support for computers or electronic notebooks;

(xiii) Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);

(xiv) Racing strollers/wheelchairs and purely recreational equipment;

(xv) Room fresheners/deodorizers;

(xvi) Bidet or hygiene systems, sharp containers, paraffin bath units, and shampoo rings;

(xvii) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(xviii) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(xix) Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

(k) Blood monitoring:

(i) Sphygmomanometer/blood pressure apparatus with cuff and stethoscope;

(ii) Blood pressure cuff only; and

(iii) Automatic blood pressure monitor.

(l) Bathroom equipment:

(i) Bath stools;

(ii) Bathtub wall rail (grab bars);

(iii) Bed pans;

(iv) Control unit for electronic bowel irrigation/evacuation system;

(v) Disposable pack for use with electronic bowel system;

(vi) Potty chairs;

(vii) Raised toilet seat;

(viii) Safety equipment (e.g. belt, harness or vest);

(ix) Shower/commode chairs;

(x) Sitz type bath or equipment;

(xi) Standard and heavy duty bath chairs;

(xii) Toilet rail;

(xiii) Transfer bench tub or toilet;

(xiv) Urinal male/female.

(m) Disinfectant spray - one twelve-ounce bottle or can per six-month period.

(n) Personal and **comfort items** including but not limited to the following:

(i) Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;

(ii) Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers, sheets, and bumper pads;

(iii) Bedside items, such as bed trays, carafes, and over-the-bed tables;

(iv) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, socks, custom vascular supports (CVS), surgical stockings, gradient compression stockings, and graduated compression stockings for pregnancy support (pantyhose style);

(v) Clothing protectors, surgical masks, and other protective cloth furniture coverings;

(vi) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(vii) Diverter valves and handheld showers for bathtub;

(viii) Eating/feeding utensils;

(ix) Emesis basins, enema bags, and diaper wipes;

(x) Health club memberships;

(xi) Hot or cold temperature food and drink containers/holders;

(xii) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;

(xiii) Impotence devices;

(xiv) Insect repellants;

(xv) Massage equipment;

(xvi) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;

(xvii) Medicine cabinet and first-aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;

(xviii) Page turners;

(xix) Radio and television;

(xx) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and

(xxi) Toothettes and toothbrushes, waterpics, and peridontal devices whether manual, battery-operated, or electric.

(o) Certain wheelchair features and options are not considered by the department to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

(i) Attendant controls (remote control devices);

(ii) Canopies, including those for strollers and other equipment;

(iii) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);

(iv) Identification devices (such as labels, license plates, name plates);

(v) Lighting systems;

(vi) Speed conversion kits; and

(vii) Tie-down restraints, except where medically necessary for client-owned vehicles.

(p) Electrical neural stimulation devices and supplies for in-home use, including battery chargers.

[Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. 10-13-167, § 388-543-1300, filed 6/23/10, effective 7/24/10. Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090. 09-22-047, § 388-543-1300, filed 10/28/09, effective 11/28/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-04-036, § 388-543-1300, filed 1/29/07, effective 3/1/07. Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-1300, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1300, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1600 Items and services which require prior authorization. (1) The department bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require **prior authorization (PA)** or **expedited prior authorization (EPA)** on utilization criteria. (See WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA.) The department considers all of the following when establishing utilization criteria:

(a) High cost;

(b) Potential for utilization abuse;

(c) Narrow therapeutic indication; and

(d) Safety.

(2) The department requires providers to obtain prior authorization for certain items and services, except for dual-eligible medicare/medicaid clients when medicare is the primary payer. This includes, but is not limited to, the following:

(a) Augmentative communication devices (ACDs);

(b) Certain by report (BR) DME and supplies as specified in the department's published issuances, including billing instructions and numbered memoranda;

(c) Blood glucose monitors requiring special features;

(d) Certain equipment rentals and certain prosthetic limbs, as specified in the department's published issuances, including billing instructions and numbered memoranda;

(e) Decubitus care products and supplies;

(f) Decubitus care mattresses, including flotation or gel mattress, if the provider fails to meet the criteria in WAC 388-543-1900;

(g) Equipment parts and labor charges for repairs or modifications and related services;

(h) Hospital beds, if the provider fails to meet the requirements in WAC 388-543-1900;

(i) Low air loss flotation system, if the provider fails to meet the requirements in WAC 388-543-1900;

(j) Orthopedic shoes and selected orthotics;

(k) Osteogenic stimulator, noninvasive, if the provider fails to meet the requirements in WAC 388-543-1900;

(l) Positioning car seats for children under five years of age;

(m) Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;

(n) Other DME not specifically listed in the department's published issuances, including billing instructions and numbered memoranda, and submitted as a miscellaneous procedure code; and

(o) Limitation extensions.

[Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. 10-13-167, § 388-543-1600, filed 6/23/10, effective 7/24/10. Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090. 09-22-047, § 388-543-1600, filed 10/28/09, effective 11/28/09. Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1600, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2800 Reusable and disposable medical supplies. (1) The department requires that a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC) prescribe reusable and disposable medical supplies. Except for dual eligible medicare/medicaid clients, the prescription must:

(a) Be dated and signed by the prescriber;

(b) Be less than six months in duration from the date the prescriber signs the prescription; and

(c) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(2) The department bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA). The department considers all of the following when establishing utilization criteria:

(a) High cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

(3) The department requires a provider to obtain a limitation extension in order to exceed the stated limits for nondurable medical equipment and medical supplies. See WAC 388-501-0165.

(4) The department categorizes medical supplies and non-DME (MSE) as follows (see WAC 388-543-1150, 388-543-1600, and department's billing instructions for further information about specific limitations and requirements for PA and EPA):

(a) Antiseptics and germicides;

(b) Bandages, dressings, and tapes;

(c) Blood monitoring/testing supplies;

(d) Braces, belts, and supportive devices;

(e) Decubitus care products;

(f) Ostomy supplies;

(g) Pregnancy-related testing kits and nursing equipment supplies;

(h) Syringes and needles;

(i) Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and

(j) Miscellaneous supplies.

[Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. 10-13-167, § 388-543-2800, filed 6/23/10, effective 7/24/10. Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-2800, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-2800, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-2800, filed 7/31/01, effective 8/31/01; 01-01-078, § 388-543-2800, filed 12/13/00, effective 1/13/01.]

Chapter 388-545 WAC
THERAPIES

WAC

388-545-300 Occupational therapy.
388-545-500 Physical therapy.

WAC 388-545-300 Occupational therapy. (1) The following providers are eligible to enroll with the department to provide occupational therapy services:

(a) A licensed occupational therapist;

(b) A licensed occupational therapy assistant supervised by a licensed occupational therapist; and

(c) An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

(2) Clients in the following department programs are eligible to receive occupational therapy services described in this chapter:

(a) Categorically needy;

(b) Children's health;

(c) General assistance unemployable (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program for emergency hospital-based services only; or

(f) Medically needy program only when the client is either:

(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program (healthy kids program) as described in chapter 388-534 WAC; or

(ii) Receiving home health care services as described in chapter 388-551 WAC, subchapter II.

(3) Occupational therapy services received by department eligible clients must be provided:

(a) As part of an outpatient treatment program for adults and children;

(b) By a home health agency as described under chapter 388-551 WAC, subchapter II;

(c) As part of the physical medicine and rehabilitation (PM&R) program as described in WAC 388-550-2551;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education program or individualized family service plan as described in WAC 388-537-0100; or

(f) When prescribed by a provider for clients age twenty-one or older. The therapy must:

(i) Prevent the need for hospitalization or nursing home care;

(ii) Assist a client in becoming employable;

(iii) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) Be a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(4) The department pays only for covered occupational therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary, when prescribed by a provider; and

(c) Begun within thirty days of the date prescribed.

(5) The department covers the following occupational therapy services per client, per calendar year:

(a) Unlimited occupational therapy program visits for clients twenty years of age or younger;

(b) One occupational therapy evaluation. The evaluation is in addition to the twelve program visits allowed per year;

(c) Two durable medical equipment needs assessments. The assessments are in addition to the twelve program visits allowed per year;

(d) Twelve occupational therapy program visits;

(e) Twenty-four additional outpatient occupational therapy program visits when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement;

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(f) Twenty-four additional occupational therapy program visits following a completed and approved inpatient PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of function due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quads only;

(ix) Bilateral limb loss; or

(x) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(g) Additional medically necessary occupational therapy services, regardless of the diagnosis, must be approved by the department.

(6) The department does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. 10-13-167, § 388-545-300, filed 6/23/10, effective 7/24/10. Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-300, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-16-068, § 388-545-300, filed 8/2/99, effective 9/2/99.]

WAC 388-545-500 Physical therapy. (1) The following providers are eligible to provide physical therapy services:

(a) A licensed physical therapist or physiatrist; or

(b) A physical therapist assistant supervised by a licensed physical therapist.

(2) Clients in the following department programs are eligible to receive physical therapy services described in this chapter:

(a) Categorically needy (CN);

(b) Children's health;

(c) General assistance-unemployable (GA-U) (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program (MIP) for emergency hospital-based services only; or

(f) Medically needy program (MNP) only when the client is either:

(i) Twenty years of age or younger and referred under the early and periodic screening, diagnosis and treatment program (EPSDT/healthy kids program) as described in WAC 388-86-027; or

(ii) Receiving home health care services as described in chapter 388-551 WAC.

(3) Physical therapy services that department eligible clients receive must be provided as part of an outpatient treatment program:

(a) In an office, home, or outpatient hospital setting;

(b) By a home health agency as described in chapter 388-551 WAC;

(c) As part of the acute physical medicine and rehabilitation (acute PM&R) program as described in the acute PM&R subchapter under chapter 388-550 WAC;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-537-0100; or

(f) For disabled children, age two and younger, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(4) The department pays only for covered physical therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary and ordered by a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP);

(c) Begun within thirty days of the date ordered;

(d) For conditions which are the result of injuries and/or medically recognized diseases and defects; and

(e) Within accepted physical therapy standards.

(5) Providers must document in a client's medical file that physical therapy services provided to clients age twenty-one and older are medically necessary. Such documentation may include justification that physical therapy services:

(a) Prevent the need for hospitalization or nursing home care;

(b) Assist a client in becoming employable;

(c) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(d) Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(6) The department determines physical therapy program units as follows:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(7) The department does not limit coverage for physical therapy services listed in subsections (8) through (10) of this section if the client is twenty years of age or younger.

(8) The department covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year, for clients twenty-one years of age and older:

(a) One physical therapy evaluation. The evaluation is in addition to the forty-eight program units allowed per year;

(b) Forty-eight physical therapy program units;

(c) Ninety-six additional outpatient physical therapy program units when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement.

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(vi) Meningomyelocele;

(vii) Down's syndrome;

(viii) Cerebral palsy; or

(ix) Symptoms involving nervous and musculoskeletal systems and lack of coordination;

(d) Two durable medical equipment (DME) needs assessments. The assessments are in addition to the forty-eight physical therapy program units allowed per year. Two program units are allowed per DME needs assessment; and

(e) One wheelchair needs assessment in addition to the two durable medical needs assessments. The assessment is in addition to the forty-eight physical therapy program units allowed per year. Four program units are allowed per wheelchair needs assessment.

(f) The following services are allowed, per day, in addition to the forty-eight physical therapy program units allowed per year:

(i) Two program units for orthotics fitting and training of upper and/or lower extremities.

(ii) Two program units for checkout for orthotic/prosthetic use.

(iii) One muscle testing procedure. Muscle testing procedures cannot be billed in combination with each other.

(g) Ninety-six additional physical therapy program units are allowed following a completed and approved inpatient acute PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient physical therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of functions due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quadriplegics only;

(ix) Bilateral limb loss;

(x) Open wound of lower limb; or

(xi) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(9) For clients age twenty-one and older, the department covers physical therapy services which exceed the limitations established in subsection (8) of this section if the provider requests prior authorization and the department approves the request.

(10) Duplicate services for occupational therapy and physical therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).

(11) The department does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(12) The department does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be billed by the hospital.

[Statutory Authority: 2009 c 564 § 1109, WAC 388-501-0055, and RCW 74.08.090. 10-13-167, § 388-545-500, filed 6/23/10, effective 7/24/10. Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-500, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 00-04-019, § 388-545-500, filed 1/24/00, effective 2/24/00.]

Chapter 388-546 WAC
TRANSPORTATION SERVICES

WAC

388-546-3000 Transporting qualified trauma cases.
388-546-5500 Modifications of privately owned vehicles—Noncovered.

WAC 388-546-3000 Transporting qualified trauma cases. The department does not pay ambulance providers who meet department of health (DOH) criteria for participation in the statewide trauma network an additional amount for transports involving qualified trauma cases described in WAC 388-550-5450. Subject to the availability of trauma care fund (TCF) monies allocated for such purpose, the department may make supplemental payments to these ambulance providers, also known as verified prehospital providers.

[Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. 10-12-013, § 388-546-3000, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-3000, filed 8/17/04, effective 9/17/04.]

WAC 388-546-5500 Modifications of privately owned vehicles—Noncovered. (1) The department does not cover the purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles under the nonemergency transportation program.

(2) The purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles is not a healthcare service. Exception to rule (ETR) as described in WAC 388-501-0160 is not available for this nonhealthcare service.

[Statutory Authority: RCW 74.08.090 and 42 C.F.R. Part 440. 10-05-079, § 388-546-5500, filed 2/15/10, effective 3/18/10. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5500, filed 3/2/01, effective 4/2/01.]

Chapter 388-548 WAC
FEDERALLY QUALIFIED HEALTH CENTERS

WAC

388-548-1000 Federally qualified health centers—Purpose.
388-548-1100 Federally qualified health centers—Definitions.
388-548-1200 Federally qualified health centers—Enrollment.
388-548-1300 Federally qualified health centers—Services.
388-548-1400 Federally qualified health centers—Reimbursement and limitations.
388-548-1500 Federally qualified health centers—Change in scope of service.

WAC 388-548-1000 Federally qualified health centers—Purpose. This chapter establishes the department's:

(1) Requirements for enrollment as a federally qualified health center (FQHC) provider; and

(2) Reimbursement methodology for services provided by FQHCs to clients of medical assistance.

[Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). 10-09-002, § 388-548-1000, filed 4/7/10, effective 5/8/10.]

WAC 388-548-1100 Federally qualified health centers—Definitions. This section contains definitions of words or phrases that apply to this chapter. Unless defined in this chapter or WAC 388-500-0005, the definitions found in the Webster's New World Dictionary apply.

APM index—The alternative payment methodology (APM) is used to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's federally qualified health center (FQHC) and rural health clinic (RHC) providers. The index is derived from the federal medicare economic index (MEI) and Washington-specific variable measures.

Base year—The year that is used as the benchmark in measuring a center's total reasonable costs for establishing base encounter rates.

Cost report—A statement of costs and provider utilization that occurred during the time period covered by the cost report. FQHCs must complete a cost report when there is a change in scope, rebasing of the encounter rate, or when the department sets a base rate.

Encounter—A face-to-face visit between a client and a FQHC provider (e.g., a physician, physician's assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

Encounter rate—A cost-based, facility-specific rate for covered FQHC services, paid to an FQHC for each valid encounter it bills.

Enhancements (also called managed care enhancements)—A monthly amount paid by the department to FQHCs for each client enrolled with a managed care organization (MCO). MCOs may contract with FQHCs to provide services under managed care programs. FQHCs receive enhancements from the department in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

Federally qualified health center (FQHC)—An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to meet medicare program requirements under 42 CFR 405.2434 and:

(1) Is receiving a grant under section 329, 330, or 340 of the Public Health Service (PHS) Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 330 of the public health service act;

(2) Based on the recommendation of the PHS, is determined by CMS to meet the requirements for receiving such a grant;

(3) Was treated by CMS, for purposes of part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990; or

(4) Is an outpatient health program or facility operated by a tribe or tribal organizations under the Indian Self-Determination Act or by an Urban Indian organization receiving funding under Title V of the Indian Health Care Improvement Act.

Fee-for-service—A payment method the department uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the department's prepaid managed care organizations or those services that qualify for an encounter rate.

Interim rate—The rate established by the department to pay an FQHC for covered FQHC services prior to the establishment of a permanent rate for that facility.

Medical assistance—The various healthcare programs administered by the department that provide federal and/or state-funded healthcare benefits to eligible clients.

Rebasing—The process of recalculating encounter rates using actual cost report data.

[Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). 10-09-002, § 388-548-1100, filed 4/7/10, effective 5/8/10.]

WAC 388-548-1200 Federally qualified health centers—Enrollment. (1) To enroll as a medical assistance provider and receive payment for services, a federally qualified health center (FQHC) must:

(a) Receive FQHC certification for participation in the Title XVIII (medicare) program according to 42 CFR 491;

(b) Sign a core provider agreement; and

(c) Operate in accordance with applicable federal, state, and local laws.

(2) The department uses one of two timeliness standards for determining the effective date of a medicaid-certified FQHC.

(a) The department uses medicare's effective date if the FQHC returns a properly completed core provider agreement and FQHC enrollment packet within sixty calendar days from the date of medicare's letter notifying the center of the medicare certification.

(b) The department uses the date the signed core provider agreement is received if the FQHC returns the properly completed core provider agreement and FQHC enrollment packet sixty-one or more calendar days after the date of medicare's letter notifying the clinic of the medicare certification.

[Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). 10-09-002, § 388-548-1200, filed 4/7/10, effective 5/8/10.]

WAC 388-548-1300 Federally qualified health centers—Services. (1) The following outpatient services qualify for FQHC reimbursement:

(a) Physician services specified in 42 CFR 405.2412.

(b) Nurse practitioner or physician assistant services specified in 42 CFR 405.2414.

(c) Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450.

(d) Visiting nurse services specified in 42 CFR 405.2416.

(e) Nurse-midwife services specified in 42 CFR 405.2401.

(f) Preventive primary services specified in 42 CFR 405.2448.

(2) The department pays for FQHC services when they are:

(a) Within the scope of an eligible client's medical assistance program. Refer to WAC 388-501-0060 scope of services; and

(b) Medically necessary as defined WAC 388-500-0005.

(3) FQHC services may be provided by any of the following individuals in accordance with 42 CFR 405.2446:

(a) Physicians;

(b) Physician assistants (PA);

(c) Nurse practitioners (NP);

(d) Nurse midwives or other specialized nurse practitioners;

(e) Certified nurse midwives;

(f) Registered nurses or licensed practical nurses; and

(g) Psychologists or clinical social workers.

[Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). 10-09-002, § 388-548-1300, filed 4/7/10, effective 5/8/10.]

WAC 388-548-1400 Federally qualified health centers—Reimbursement and limitations. (1) Effective January 1, 2001, the payment methodology for federally qualified health centers (FQHC) conforms to 42 U.S.C. 1396a(bb). As set forth in 42 U.S.C. 1396a (bb)(2) and (3), all FQHCs that provide services on January 1, 2001, and through December 31, 2008, are reimbursed on a prospective payment system (PPS).

(2) Effective January 1, 2009, FQHCs have the choice to continue being reimbursed under the PPS or to be reimbursed under an alternative payment methodology (APM), as authorized by 42 U.S.C. 1396a (bb)(6). As required by 42 U.S.C. 1396a(bb), payments made under the APM must be at least as much as payments that would have been made under the PPS.

(3) The department calculates the FQHC's PPS encounter rate as follows:

(a) Until the FQHC's first audited cost report is available, the department pays an average encounter rate of other similar FQHCs within the state, otherwise known as an interim rate;

(b) Upon availability of the FQHC's first audited medicaid cost report, the department sets the clinic's encounter rate at one hundred percent of its total reasonable costs as defined in the cost report. The FQHC receives this rate for the remainder of the calendar year during which the audited cost report became available. Thereafter, the encounter rate is then inflated each January 1 by the medicare economic index (MEI) for primary care services.

(4) For FQHCs in existence during calendar years 1999 and 2000, the department sets the payment prospectively using a weighted average of one hundred percent of the center's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The department adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 388-548-1500.

(b) The PPS base encounter rates are determined using audited cost reports and each year's rate is weighted by the total reported encounters. The department does not apply a capped amount to these base encounter rates. The formula used to calculate the base encounter rate is as follows:

$$\text{Specific FQHC Base Encounter Rate} = \frac{(1999\ \text{Rate} \times 1999\ \text{Encounters}) + (2000\ \text{Rate} \times 2000\ \text{Encounters})}{(1999\ \text{Encounters} + 2000\ \text{Encounters})\ \text{for each FQHC}}$$

(c) Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the MEI for primary care services, and adjusted for any increase or decrease within the center's scope of services.

(5) The department calculates the FQHC's APM encounter rate as follows:

(a) Beginning January 1, 2009, the APM utilizes the FQHC base encounter rates, as described in WAC 388-548-1400 (4)(b).

(i) The base rates are adjusted to reflect any valid changes in scope of service between years 2002 and 2009.

(ii) The adjusted base rates are then inflated by each annual percentage, from years 2002 through 2009, of the APM index. The result is the year 2009 APM rate for each FQHC that chooses to be reimbursed under the APM.

(b) The department will ensure that the APM pays an amount that is at least equal to the PPS, the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.

(c) The department will periodically rebase the APM rates. The department will not rebase rates determined under the PPS.

(6) The department limits encounters to one per client, per day except in the following circumstances:

(a) The visits occur with different healthcare professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(7) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(8) Payments for nonFQHC services provided in an FQHC are made on a fee-for-service basis using the department's published fee schedules. NonFQHC services are subject to the coverage guidelines and limitations listed in chapters 388-500 through 557 WAC.

(9) For clients enrolled with a managed care organization, covered FQHC services are paid for by that plan.

(10) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The department does not pay the encounter rate or the enhancement rate for clients in state-only medical programs. Services provided to clients in state-only medical programs are considered fee-for-service regardless of the type of service performed.

(11) For clients enrolled with a managed care organization (MCO), the department pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

(a) The FQHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

(b) To ensure that the appropriate amounts are paid to each FQHC, the department performs an annual reconciliation of the enhancement payments. For each FQHC, the department will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less FFS equivalent of

MCO services. If the center has been overpaid, the department will recoup the appropriate amount. If the center has been underpaid, the department will pay the difference.

[Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). 10-09-002, § 388-548-1400, filed 4/7/10, effective 5/8/10.]

WAC 388-548-1500 Federally qualified health centers—Change in scope of service. (1) For centers reimbursed under the prospective payment system (PPS), the department considers a federally qualified health center (FQHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the FQHC. Changes in scope of service apply only to covered medicaid services.

(2) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the FQHC's encounter rate to reflect the change.

(3) FQHCs must:

(a) Notify the department's FQHC program manager in writing, at the address published in the department's federally qualified health centers billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and

(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(4) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

(a) A medicaid comprehensive desk review of the FQHC's cost report;

(b) Review of a medicare audit of the FQHC's cost report; or

(c) Other documentation relevant to the change in scope of service.

(5) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

(6) For centers reimbursed under the alternative payment methodology (APM), the department considers an FQHC change in scope of service to be a change in the type of services provided by the FQHC. Changes in intensity, duration, and/or amount of services will be addressed in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered medicaid services.

(7) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the FQHC's encounter rate to reflect the change.

(8) FQHCs must:

(a) Notify the department's FQHC program manager in writing, at the address published in the department's FQHC billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and

(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(9) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

(a) A medicaid comprehensive desk review of the FQHC's cost report;

(b) Other documentation relevant to the change in scope of service.

(10) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

[Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). 10-09-002, § 388-548-1500, filed 4/7/10, effective 5/8/10.]

Chapter 388-549 WAC
RURAL HEALTH CLINICS

WAC

388-549-1100 Rural health clinics—Definitions.
388-549-1400 Rural health clinics—Reimbursement and limitations.
388-549-1500 Rural health clinics—Change in scope of service.

WAC 388-549-1100 Rural health clinics—Definitions. This section contains definitions of words and phrases that apply to this chapter. Unless defined in this chapter or WAC 388-500-0005, the definitions found in the Webster's New World Dictionary apply.

"APM index"—The alternative payment methodology (APM) is used to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's federally qualified health center (FQHC) and rural health clinic (RHC) providers.

"Base year"—The year that is used as the benchmark in measuring a clinic's total reasonable costs for establishing base encounter rates.

"Encounter"—A face-to-face visit between a client and a qualified rural health clinic (RHC) provider (e.g., a physician, physician's assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

"Encounter rate"—A cost-based, facility-specific rate for covered RHC services, paid to a rural health clinic for each valid encounter it bills.

"Enhancements" (also called managed care enhancements)—A monthly amount paid to RHCs for each client enrolled with a managed care organization (MCO). MCOs may contract with RHCs to provide services under managed care programs. RHCs receive enhancements from the department in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

"Fee-for-service"—A payment method the department uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the department's prepaid managed care organizations or those services that qualify for an encounter payment.

"Interim rate"—The rate established by the department to pay a rural health clinic for covered RHC services prior to the establishment of a permanent rate for that facility.

"Medical assistance"—The various healthcare programs administered by the department that provide federal and/or state-funded benefits to eligible clients.

"Medicare cost report"—The cost report is a statement of costs and provider utilization that occurred during the time

period covered by the cost report. RHCs must complete and submit a report annually to medicare.

"Mobile unit"—The objects, equipment, and supplies necessary for provision of the services furnished directly by the RHC are housed in a mobile structure.

"Permanent unit"—The objects, equipment and supplies necessary for the provision of the services furnished directly by the clinic are housed in a permanent structure.

"Rebasing"—The process of recalculating encounter rates using actual cost report data.

"Rural area"—An area that is not delineated as an urbanized area by the Bureau of the Consensus.

"Rural health clinic (RHC)"—A clinic, as defined in 42 CFR 405.2401(b), that is primarily engaged in providing RHC services and is:

• Located in a rural area designated as a shortage area as defined under 42 CFR 491.2;

• Certified by medicare as a RHC in accordance with applicable federal requirements; and

• Not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural health clinic (RHC) services"—Outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic or similar setting, including specified types of diagnostic examination, laboratory services, and emergency treatments. The specific list of services which must be made available by the clinic can be found under 42 CFR part 491.9.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491. 10-09-030, § 388-549-1100, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1100, filed 2/7/08, effective 3/9/08.]

WAC 388-549-1400 Rural health clinics—Reimbursement and limitations. (1) Effective January 1, 2001, the payment methodology for rural health clinics (RHC) conforms to 42 USC 1396a(bb). RHCs that provide services on January 1, 2001 through December 31, 2008 are reimbursed on a prospective payment system (PPS).

Effective January 1, 2009, RHCs have the choice to continue being reimbursed under the PPS or be reimbursed under an alternative payment methodology (APM), as authorized by 42 USC 1396a (bb)(6). As required by 42.U.S.C. 1396a (bb), payments made under the APM must be at least as much as payments that would have been made under the PPS.

(2) The department calculates the RHC's PPS encounter rate for RHC core services as follows:

(a) Until the RHC's first audited medicare cost report is available, the department pays an average encounter rate of other similar RHCs (whether the RHC is classified as hospital-based or free-standing) within the state, otherwise known as an interim rate.

(b) Upon availability of the RHC's audited medicare cost report, the department sets the clinic's encounter rate at one hundred percent of its costs as defined in the cost report divided by the total number of encounters the clinic has provided during the time period covered in the audited cost report. The RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then inflated each January 1 by the medicare economic index (MEI) for primary care services.

(3) For RHCs in existence during calendar years 1999 and 2000, the department sets the payment prospectively using a weighted average of one hundred percent of the clinic's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The department adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 388-549-1500.

(b) The PPS base encounter rates are determined using medicare's audited cost reports and each year's rate is weighted by the total reported encounters. The department does not apply a capped amount to these base encounter rates. The formula used to calculate the base encounter rate is as follows:

$$\text{Specific RHC Base Encounter Rate} = \frac{(1999\ \text{Rate} \times 1999\ \text{Encounters}) + (2000\ \text{Rate} \times 2000\ \text{Encounters})}{(1999\ \text{Encounters} + 2000\ \text{Encounters})\ \text{for each RHC}}$$

(c) Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the MEI and adjusted for any increase or decrease in the clinic's scope of services.

(4) The department calculates the RHC's APM encounter rate as follows:

(a) Beginning January 1, 2009, the APM utilizes RHC base encounter rates as described in WAC 388-549-1400 (3)(b). The base rates are inflated by each annual percentage, from years 2002 through 2009, of the APM index. The result is the year 2009 APM rate for each RHC that chooses to be reimbursed under the APM.

(b) To ensure that the APM pays an amount that is at least equal to the PPS in accordance with 42 USC 1396a (bb)(6), the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.

(c) The department periodically rebases the APM rates. The department does not rebase rates determined under the PPS.

(d) When rebasing the APM encounter rates, the department applies a productivity standard to the number of visits performed by each practitioner group (physicians and mid-levels) to determine the number of encounters to be used in each RHC's rate calculation. The productivity standards are determined by reviewing all available RHC cost reports for the rebasing period and setting the standards at the levels necessary to allow ninety-five percent of the RHCs to meet the standards. The encounter rates of the clinics that meet the standards are calculated using each clinic's actual number of encounters. The encounter rates of the other five percent of clinics are calculated using the productivity standards. This process is applied at each rebasing, so the actual productivity standards may change each time encounter rates are rebased.

(5) The department pays for one encounter, per client, per day except in the following circumstances:

(a) The visits occur with different healthcare professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(6) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(7) Payments for non-RHC services provided in an RHC are made on a fee-for-service basis using the department's published fee schedules. Non-RHC services are subject to the coverage guidelines and limitations listed in chapters 388-500 through 388-557 WAC.

(8) For clients enrolled with a managed care organization, covered RHC services are paid for by that plan.

(9) The department does not pay the encounter rate or the enhancements for clients in state-only programs. Services provided to clients in state-only programs are considered fee-for-service, regardless of the type of service performed.

(10) For clients enrolled with a managed care organization (MCO), the department pays each RHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 USC 1396a (bb)(5)(A).

(a) The RHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

(b) To ensure that the appropriate amounts are paid to each RHC, the department performs an annual reconciliation of the enhancement payments. For each RHC, the department will compare the amount actually paid to the amount determined by the following formula: (managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the clinic has been overpaid, the department will recoup the appropriate amount. If the clinic has been underpaid, the department will pay the difference.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491. 10-09-030, § 388-549-1400, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1400, filed 2/7/08, effective 3/9/08.]

WAC 388-549-1500 Rural health clinics—Change in scope of service. (1) For clinics reimbursed under the prospective payment system (PPS), the department considers a rural health clinic's (RHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the RHC. Changes in scope of service apply only to covered medicaid services.

(a) When the department determines that a change in scope of service has occurred after the base year, the department will adjust the RHC's encounter rate to reflect the change.

(b) RHCs must:

(i) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of service no later than sixty days after the effective date of the change; and

(ii) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(c) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

(i) A medicaid comprehensive desk review of the RHC's cost report;

(ii) Review of a medicare audit of the RHC's cost report; or

(iii) Other documentation relevant to the change in scope of service.

(d) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

(2) For clinics reimbursed under the alternative payment methodology (APM), the department considers an RHC change in scope of service to be a change in the type of services provided by the RHC. The department addresses changes in intensity, duration, and/or amount of services in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered medicaid services.

(a) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the RHC's encounter rate to reflect the change.

(b) RHCs must:

(i) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and

(ii) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(c) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

(i) A medicaid comprehensive desk review of the RHC's cost report;

(ii) Review of a medicare audit of the RHC's cost report, if available; or

(iii) Other documentation relevant to the change in scope of service.

(d) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491. 10-09-030, § 388-549-1500, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1500, filed 2/7/08, effective 3/9/08.]

Chapter 388-550 WAC
HOSPITAL SERVICES

WAC

388-550-4670 CPE payment program—"Hold harmless" provision.
388-550-4900 Disproportionate share hospital (DSH) payments—General provisions.
388-550-5000 Payment method—Low income disproportionate share hospital (LIDSH).
388-550-5150 Payment method—General assistance-unemployable disproportionate share hospital (GAUDSH).
388-550-5200 Payment method—Small rural disproportionate share hospital (SRDSH).

388-550-5210	Payment method—Small rural indigent assistance disproportionate share hospital (SRIADSH).
388-550-5220	Payment method—Nonrural indigent assistance disproportionate share hospital (NRIADSH).
388-550-5450	Supplemental distributions to approved trauma service centers.
388-550-7050	OPPS—Definitions.
388-550-7200	OPPS—Billing requirements and payment method.
388-550-7300	OPPS—Payment limitations.

WAC 388-550-4670 CPE payment program—"Hold harmless" provision. To meet legislative requirements, the department includes a "hold harmless" provision for hospital providers eligible for the certified public expenditure (CPE) payment program. Under the provision and subject to legislative directives and appropriations, hospitals eligible for payments under the CPE payment program will receive no less in combined state and federal payments than they would have received under the methodologies otherwise in effect as described in this section. All hospital submissions pertaining to the CPE payment program, including but not limited to cost report schedules, are subject to audit at any time by the department or its designee.

(1) The department:

(a) Uses historical cost and payment data trended forward to calculate prospective hold harmless grant payment amounts for the current state fiscal year (SFY); and

(b) Reconciles these hold harmless grant payment amounts when the actual claims data are available for the current fiscal year.

(2) For SFYs 2006 through 2009, the department calculates what the hospital would have been paid under the methodologies otherwise in effect for the SFY as the sum of:

(a) The total payments for inpatient claims for patients admitted during the fiscal year, calculated by repricing the claims using:

(i) For SFYs 2006 and 2007, the inpatient payment method in effect during SFY 2005; or

(ii) For SFYs 2008 and 2009, the payment method that would otherwise be in effect during the CPE payment program year if the CPE payment program had not been enacted.

(b) The total net disproportionate share hospital and state grant payments paid for SFY 2005.

(3) For SFY 2010 and beyond, the department calculates what the hospital would have been paid under the methodologies otherwise in effect for the SFY as the sum of:

(a) The total of the inpatient claim payment amounts that would have been paid during the SFY had the hospital not been in the CPE payment program;

(b) One-half of the indigent assistance disproportionate share hospital payment amounts paid to and retained by each hospital during SFY 2005; and

(c) All of the other disproportionate share hospital payment amounts paid to and retained by each hospital during SFY 2005 to the extent the same disproportionate share hospital programs exist in the 2009-2011 biennium.

(4) For each SFY, the department determines total state and federal payments made under the program, including:

(a) Inpatient claim payments;

(b) Disproportionate share hospital (DSH) payments; and

(c) Supplemental upper payment limit payments, as applicable.

(5) A hospital may receive a hold harmless grant, subject to legislative directives and appropriations, when the following calculation results in a positive number:

(a) For SFY 2006 through SFY 2009, the amount derived in subsection (4) of this section is subtracted from the amount derived in subsection (2) of this section; or

(b) For SFY 2010 and beyond, the amount derived in subsection (4) of this section is subtracted from the amount derived in subsection (3) of this section.

(6) The department calculates interim hold harmless and final hold harmless grant amounts as follows:

(a) An interim hold harmless grant amount is calculated approximately ten months after the end of the SFY to include the paid claims for the same SFY admissions. Claims are subject to utilization review prior to the interim hold harmless calculation. Prospective grant payments made under subsection (1) of this section are deducted from the calculated interim hold harmless grant amount to determine the net grant payment amount due to or due from the hospital.

(b) The final hold harmless grant amount is calculated at such time as the final allowable federal portions of program payments are determined. The procedure is the same as the interim grant calculation but it includes all additional claims that have been paid or adjusted since the interim hold harmless calculation. Claims are subject to utilization review and audit prior to the final calculation of the hold harmless amount. Interim grant payments determined under (a) of this subsection are deducted from this final calculation to determine the net final hold harmless amount due to or due from the hospital.

[Statutory Authority: 2009 c 564 §§ 201 and 209, RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 10-11-032, § 388-550-4670, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090 and 74.09.500. 08-20-032, § 388-550-4670, filed 9/22/08, effective 10/23/08; 07-14-090, § 388-550-4670, filed 6/29/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518 § 209(9). 06-11-100, § 388-550-4670, filed 5/17/06, effective 6/17/06.]

WAC 388-550-4900 Disproportionate share hospital (DSH) payments—General provisions. (1) As required by section 1902 (a)(13)(A) of the Social Security Act (42 USC 1396 (a)(13)(A)) and RCW 74.09.730, the department makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 USC 1396r-4;

(b) It satisfies all the requirements of department rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means the twelve-month medicare cost report year that ended during the calendar year immediately preceding the year in which the state fiscal year (SFY) for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid medicaid claims during the SFY two

years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the department which the department uses to verify medicaid client eligibility and applicable inpatient days.

(e) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the department during a SFY. If a hospital does not qualify for DSH, the department will not calculate the hospital-specific DSH cap and the hospital will not receive DSH payments.

(f) "Inpatient medicaid days" means inpatient days attributed to clients eligible for Title XIX medicaid programs. Excluded from this count are inpatient days attributed to clients eligible for state administered programs, medicare Part A, Title XXI, the refugee program and the TAKE CHARGE program.

(g) "Low income utilization rate (LIUR)" the sum of two percentages:

(i) The ratio of payments received by the hospital for patient services provided to clients under medicaid (including managed care), plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus

(ii) The ratio of inpatient charity care charges less inpatient cash subsidies received by the hospital from state and local governments, less contractual allowances and discounts, divided by total charges for inpatient services.

(h) "Medicaid inpatient utilization rate (MIPUR)" is calculated as a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to clients who (for such days) were eligible for medical assistance during the base year (regardless of whether such clients received medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. "Inpatient days" include each day in which a person (including a newborn) is an inpatient in the hospital, whether or not the person is in a specialized ward and whether or not the person remains in the hospital for lack of suitable placement elsewhere.

(i) "Medicare cost report year" means the twelve-month period included in the annual cost report a medicare-certified hospital or institutional provider is required by law to submit to its fiscal intermediary.

(j) "Nonrural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 388-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(iii) Is not a small rural hospital as defined in (n) of this subsection; and

(iv) Is located in the state of Washington or in a designated bordering city. For DSH purposes, the department considers as nonrural any hospital located in a designated bordering city.

(k) "Obstetric services" means routine, nonemergency obstetric services and the delivery of babies.

(l) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or medicare cost report year, or to a state fiscal year.

(m) "Statewide disproportionate share hospital (DSH) cap" is the maximum amount per SFY that the state can distribute in DSH payments to all qualifying hospitals during a SFY.

(n) "Small rural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 388-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(iii) Has fewer than seventy-five acute beds;

(iv) Is located in the state of Washington; and

(v) Is located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(o) "Uninsured patient" is a person without creditable coverage as defined in 45 C.F.R. 146.113. (An "insured patient," for DSH program purposes, is a person with creditable coverage, even if the insurer did not pay the full charges for the service.) To determine whether a service provided to an uninsured patient may be included for DSH application and calculation purposes, the department considers only services that would have been covered and paid through the department's fee-for-service process.

(4) To be considered for a DSH payment for each SFY, a hospital must meet the criteria in this section:

(a) DSH application requirement.

(i) Only a hospital located in the state of Washington or in a designated bordering city is eligible to apply for and receive DSH payments. An institution for mental disease (IMD) owned and operated by the state of Washington is exempt from the DSH application requirement.

(ii) A hospital that meets DSH program criteria is eligible for DSH payments in any SFY only if the department receives the hospital's DSH application by the deadline posted on the department's website.

(b) DSH application review and correction period.

(i) This subsection applies only to DSH applications that meet the requirements under (a) of this subsection.

(ii) The department reviews and may verify any information provided by the hospital on a DSH application. However, each hospital has the responsibility for ensuring its DSH application is complete and accurate.

(iii) If the department finds that a hospital's application is incomplete or contains incorrect information, the department

will notify the hospital. The hospital must resubmit a new, corrected application. The department must receive the new DSH application from the hospital by the deadline for corrected DSH applications posted on the department's website.

(iv) If a hospital finds that its application is incomplete or contains incorrect information, it may choose to submit changes and/or corrections to the DSH application. The department must receive the corrected, complete, and signed DSH application from the hospital by the deadline for corrected DSH applications posted on the department's website.

(c) Official DSH application.

(i) The department considers as official the last signed DSH application submitted by the hospital as of the deadline for corrected DSH applications. A hospital cannot change its official DSH application. Only those hospitals with an official DSH application are eligible for DSH payments.

(ii) If the department finds that a hospital's official DSH application is incomplete or contains inaccurate information that affects the hospital's LIDSH payment(s), the hospital does not qualify for, will not receive, and cannot retain, LIDSH payment(s). Refer to WAC 388-550-5000.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital satisfies the medicaid inpatient utilization rate (MIPUR) requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a MIPUR greater than one percent; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age eighteen; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) To determine a hospital's MIPUR, the department uses inpatient days as follows:

(a) The total inpatient days on the official DSH application if this number is greater than the total inpatient hospital days on the medicare cost report; and

(b) The MMIS medicaid days as determined by the DSH reporting data file (DRDF) process if the Washington state medicaid days on the official DSH application do not match the eligible days on the final DRDF. If the hospital did not submit a DRDF, the department uses paid medicaid days from MMIS.

(7) The department administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Institution for mental diseases disproportionate share hospital (IMDDSH):

(c) General assistance-unemployable disproportionate share hospital (GAUDSH);

(d) Small rural disproportionate share hospital (SRDSH);

(e) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(f) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(g) Public hospital disproportionate share hospital (PHDSH); and

(h) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

(8) Except for IMDDSH, the department allows a hospital to receive any one or all of the DSH payment it qualifies for, up to the individual hospital's DSH cap (see subsection (10) of this section) and provided that total DSH payments do not exceed the statewide DSH cap. See WAC 388-550-5130 regarding IMDDSH. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the department calculates DSH payments for each DSH program for eligible hospitals using data from each hospital's base year. The department does not use base year data for GAUDSH and PIIDSH payments, which are calculated based on specific claims data.

(10) The department's total DSH payments to a hospital for any given SFY cannot exceed the hospital-specific DSH cap for that SFY. Except for critical access hospitals (CAHs), the department determines a hospital's DSH cap as follows. The department:

(a) Uses the overall ratio of costs-to-charges (RCC) to determine costs for:

(i) Medicaid services, including medicaid services provided under managed care organization (MCO) plans; and

(ii) Uninsured charges; then

(b) Subtracts all payments related to the costs derived in (a) of this subsection; then

(c) Makes any adjustments required and/or authorized by federal statute or regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to medicaid clients served under MCO plans, and uninsured patients. To determine a CAH's DSH cap amount, the department:

(a) Uses the overall RCC to determine costs for:

(i) Medicaid services provided under MCO plans; and

(ii) Uninsured charges; then

(b) Subtracts the total payments made by, or on behalf of, the medicaid clients serviced under MCO plans, and uninsured patients.

(12) In any given federal fiscal year, the total of the department's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the department's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the department will adjust DSH payments to each hospital to account for the amount overpaid. The department makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;
(c) SRDSH;
(d) NRIADSH;
(e) GAUDSH;
(f) PIIDSH;
(g) IMDDSH; and
(h) LIDSH.

(14) If the statewide DSH cap is exceeded, the department will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program WACs for description of how amounts to be recouped are determined.

(15) The total amount the department may distribute annually under a particular DSH program is capped by legislative appropriation, except for PHDSH, GAUDSH, and PIIDSH, which are not fixed amounts. Any changes in payment amount to a hospital in a particular DSH program means a redistribution of payments within that DSH program. When necessary, the department will recoup from hospitals to make additional payments to other hospitals within that DSH program.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the department will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program.

(b) If an individual hospital has been underpaid by a specified amount, the department will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH program. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH program.

(17) All information related to a hospital's DSH application is subject to audit by the department or its designee. The department determines the extent and timing of the audits. For example, the department or its designee may choose to do a desk review of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the department will recoup the overpayment amount, in accordance with the provisions of RCW 74.09.220 and 43.20B.695.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific SFY. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full SFY in which the rules are adopted.

[Statutory Authority: 2009 c 564 §§ 201 and 209, RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 10-11-032, § 388-550-4900, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-4900, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-4900, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-4900, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-4900, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-4900, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5000 Payment method—Low income disproportionate share hospital (LIDSH). (1) The department makes low income disproportionate share hospital (LIDSH) payments to qualifying hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an LIDSH payment, a hospital must:

(a) Not be a hospital eligible for public disproportionate share (PHDSH) payments (see WAC 388-550-5400);

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (4) and (5);

(d) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive LIDSH payments; and

(e) Meet at least one of the following requirements. The hospital must:

(i) Have a medicaid inpatient utilization rate (MIPUR) as defined in WAC 388-550-4900 (3)(h) at least one standard deviation above the mean medicaid inpatient utilization rate of in-state hospitals that receive medicaid payments; or

(ii) Have a low income utilization rate (LIUR) as defined in WAC 388-550-4900 (3)(g) that exceeds twenty-five percent.

(3) The department pays hospitals qualifying for LIDSH payments from a legislatively appropriated pool. The maximum amount of LIDSH payments in any state fiscal year (SFY) is the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(4) The department determines LIDSH payments to each LIDSH eligible hospital using the following factors from the specific hospital's base year as defined in WAC 388-550-4900 (3)(a):

(a) The hospital's medicaid inpatient utilization rate (MIPUR) (see WAC 388-550-4900 for how the department calculates the MIPUR).

(b) The hospital's medicaid case mix index (CMI). The department calculates the CMI by:

(i) Using the DRG weight for each of the hospital's paid inpatient claims assigned in the year the claim was paid;

(ii) Summing the DRG weights; and

(iii) Dividing this total by the number of claims.

The CMI the department uses for LIDSH calculations is not the same as the CMI the department uses in other hospital rate calculations.

(c) The number of the hospital's Title XIX medicaid discharges. The department includes in this number only the discharges pertaining to Washington state medicaid clients.

(5) The department calculates the LIDSH payment to an eligible hospital as follows.

(a) The department:

(i) Divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(ii) Multiplies the result derived in (a) of this section by the CMI (see (4)(b) of this section), and then by the discharges (see (4)(c) of this section); then

(iii) Converts the product to a percentage of the sum of all such products for individual hospitals; and

(iv) Multiplies this percentage by the legislatively appropriated amount for LIDSH.

(b) If a hospital's calculated LIDSH payment is greater than the hospital-specific DSH cap, the payment to the hospital is limited to the hospital-specific DSH cap, and the department:

(i) Subtracts the LIDSH payment calculated for the hospital to determine the remaining LIDSH appropriation to distribute to the other qualifying hospitals; and

(ii) Proportionately distributes the remaining LIDSH appropriation in accordance with the factors in (a) of this subsection.

(6) A hospital receiving LIDSH payments must comply with a department request for uninsured logs (uninsured logs are documentation of payments, charges, and other information for uninsured patients) to verify its hospital-specific DSH cap.

(7) The department will not make changes in the LIDSH payment distribution after the applicable SFY has ended. The department recalculates the LIDSH payment distribution only when the applicable SFY has not yet ended at the time the alleged need for an LIDSH adjustment is identified, and if the department considers the recalculation necessary and appropriate under its regulations.

(8) Consistent with the provisions of subsection (7) of this section, the department applies any adjustments to the DSH payment distribution required by legislative, administrative, or other state action, to other DSH programs in accordance with the provisions of WAC 388-550-4900 (13) through (16).

[Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). 10-17-095, § 388-550-5000, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-5000, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5000, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-5000, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-5000, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5150 Payment method—General assistance-unemployable disproportionate share hospital (GAUDSH). (1) A hospital is eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900;

(b) Is an in-state or designated bordering city hospital;

(c) Provides services to clients eligible under the medical care services program; and

(d) Has a medicaid inpatient utilization rate (MIPUR) of one percent or more.

(2) The department determines the GAUDSH payment for each eligible hospital in accordance with:

(a) WAC 388-550-4800 for inpatient hospital claims submitted for general assistance unemployable (GAU) clients; and

(b) WAC 388-550-7000 through 388-550-7600 and other sections in chapter 388-550 WAC that pertain to outpatient hospital claims submitted for GAU clients.

(3) The department makes GAUDSH payments to a hospital on a claim-specific basis.

[Statutory Authority: 2009 c 564 §§ 201 and 209, RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 10-11-032, § 388-550-5150, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-5150, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5150, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-5150, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5150, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5200 Payment method—Small rural disproportionate share hospital (SRDSH). (1) The department makes small rural disproportionate share hospital (SRDSH) payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRDSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 388-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (4) and (5);

(d) Have fewer than seventy-five acute beds;

(e) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRDSH payments; and

(f) Be located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns, and counties used for the allocation of state revenues. This nonstudent population is used for state fiscal year (SFY) 2010, which began July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(3) The department pays hospitals qualifying for SRDSH payments from a legislatively appropriated pool. The department determines each hospital's individual SRDSH payment from the total dollars in the pool using percentages established as follows:

(a) At the time the SRDSH payment is to be made, the department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies the medicaid payment amounts made by the department to the individual hospital during the SFY two years prior to the current SFY for which DSH application is being made. These medicaid payment amounts are based on historical data considered to be complete; then

(ii) Multiplies the total medicaid payment amount determined in subsection (i) by the individual hospital's assigned profit factor (1.1 or 1.0) to identify a revised medicaid payment amount; and

(iii) Divides the revised medicaid payment amount for the individual hospital by the sum of the revised medicaid payment amounts for all qualifying hospitals during the same period.

(4) The department's SRDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured patients for that hospital unless an exception is required by federal statute or regulation.

(5) The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). 10-17-095, § 388-550-5200, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-5200, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5200, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5200, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-5200, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5200, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5210 Payment method—Small rural indigent assistance disproportionate share hospital (SRIADSH). (1) The department makes small rural indigent assistance disproportionate share hospital (SRIADSH) program payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRIADSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 388-550-4650;

(b) Not be designated as an "institution for mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (4) and (5);

(d) Have fewer than seventy-five acute beds;

(e) Be an in-state hospital that provided charity services to clients during the base year. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRIADSH payments; and

(f) Be located in a city or town with a nonstudent population of no more than seventeen thousand eight hundred six in calendar year 2008, as determined by the Washington State office of financial management population of cities, towns, and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population ceiling is increased by two percent.

(3) The department pays hospitals qualifying for SRIADSH payments from a legislatively appropriated pool. The department determines each hospital's individual SRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the SRIADSH payment is to be made, the department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department determines the average profitability margin for all hospitals qualifying for SRIADSH.

(c) Any qualifying hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other qualifying hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of revised costs by dividing its revised cost amount by the sum of the revised charity cost amounts for all qualifying hospitals during the same period.

(4) The department's SRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for that hospital unless an exception is required by federal statute or regulation. The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). 10-17-095, § 388-550-5210, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-5210, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5210, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-5210, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5210, filed 5/28/04, effective 7/1/04.]

WAC 388-550-5220 Payment method—Nonrural indigent assistance disproportionate share hospital (NRIADSH). (1) The department makes nonrural indigent assistance disproportionate share hospital (NRIADSH) payments to qualifying nonrural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an NRIADSH payment, a hospital must:

(a) Not be participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 388-550-4650;

(b) Not be designated as an "institution of mental diseases (IMD)" as defined in WAC 388-550-2600 (2)(d);

(c) Meet the criteria in WAC 388-550-4900 (4) and (5);

(d) Be a hospital that does not qualify as a small rural hospital as defined in WAC 388-550-4900 (3)(n); and

(e) Be an in-state or designated bordering city hospital that provided charity services to clients during the base year. For DSH purposes, the department considers as nonrural any hospital located in a designated bordering city.

(3) The department pays hospitals qualifying for NRIADSH payments from a legislatively appropriated pool. The department determines each hospital's individual NRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the NRIADSH payment is to be made, the department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of the NRIADSH revised costs by dividing the hospital's revised cost amount by the total revised charity costs for all qualifying hospitals during the same period.

(4) The department's NRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for the hospital unless an exception is required by federal statute or regulation. The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.730(2). 10-17-095, § 388-550-5220, filed 8/17/10, effective 9/17/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-14-090, § 388-550-5220, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5220, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-5220, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5220, filed 5/28/04, effective 7/1/04.]

WAC 388-550-5450 Supplemental distributions to approved trauma service centers. (1) The trauma care fund (TCF) is an amount legislatively appropriated to the department each biennium, at the legislature's sole discretion, for the purpose of supplementing the department's payments to eligible trauma service centers for providing qualified trauma services to medicaid fee-for-service clients. Claims for trauma care provided to clients enrolled in the department's managed care programs are not eligible for supplemental distributions from the TCF.

(2) The department makes supplemental distributions from the TCF to qualified hospitals, subject to the provisions in this section and subject to legislative action.

(3) To qualify for supplemental distributions from the TCF, a hospital must:

(a) Be designated or recognized by the department of health (DOH) as an approved Level I, Level II, or Level III adult or pediatric trauma service center;

(b) Meet the provider requirements in this section and other applicable WAC;

(c) Meet the billing requirements in this section and other applicable WAC;

(d) Submit all information the department requires to monitor the program; and

(e) Comply with DOH's Trauma Registry reporting requirements.

(4) Supplemental distributions from the TCF are:

(a) Allocated into five payment pools. Timing of payments is described in subsection (5) of this section. Distributions from the payment pools to the individual hospitals are determined by first summing each eligible hospital's qualifying payments since the beginning of the service year and expressing this amount as a percentage of total payments to all eligible hospitals for qualifying services provided during the service year to date. For TCF purposes, service year is defined as the state fiscal year. Each hospital's qualifying payment percentage for the service year-to-date is multiplied by the available amount for the service year-to-date, and then the department subtracts what has been allocated to each hospital for the service year-to-date to determine the portion of the current payment pool to be paid to each qualifying hospital. This method for determining supplemental distributions to hospitals applies to TCF allotments beginning with state fiscal year (SFY) 2008. Eligible hospitals and qualifying payments are described in (i) through (iii) of this subsection:

(i) Qualifying payments are the department's payments to Level I, Level II, and Level III trauma service centers for qualified medicaid trauma cases since the beginning of the service year. The department determines the countable payment for trauma care provided to medicaid clients based on date of service, not date of payment;

(ii) The department's payments to Level I, Level II, and Level III hospitals for trauma cases transferred in since the beginning of the service year. A Level I, Level II, or Level III hospital that receives a transferred trauma case from any lower level hospital is eligible for the enhanced payment, regardless of the client's injury severity score (ISS); and

(iii) The department's payments to Level II and Level III hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in subsection (4)(b) of this section) transferred by these hospitals since the beginning of the service year to a trauma service center with a higher designation level.

(b) Paid only for a medicaid trauma case that meets:

(i) The ISS of thirteen or greater for an adult trauma patient (a client age fifteen or older);

(ii) The ISS of nine or greater for a pediatric trauma patient (a client younger than age fifteen); or

(iii) The conditions of subsection (4)(c).

(c) Made to hospitals, as follows, for a trauma case that is transferred:

(i) A hospital that receives the transferred trauma case qualifies for payment regardless of the ISS if the hospital is

designated or recognized by DOH as an approved Level I, Level II, or Level III adult or pediatric trauma service center;

(ii) A hospital that transfers the trauma case qualifies for payment only if:

(A) It is designated or recognized by DOH as an approved Level II or Level III adult or pediatric trauma service center; and

(B) The ISS requirements in (b)(i) or (b)(ii) of this subsection are met.

(iii) A hospital that DOH designates or recognizes as an approved Level IV or Level V trauma service center does not qualify for supplemental distributions for trauma cases that are transferred in or transferred out, even when the transferred cases meet the ISS criteria in subsection (4)(b) of this section.

(d) Not funded by disproportionate share hospital (DSH) funds; and

(e) Not distributed by the department to:

(i) Trauma service centers designated or recognized as Level IV or Level V;

(ii) Critical access hospitals (CAHs), except when the CAH is also a Level III trauma service center. Beginning with qualifying trauma services provided in SFY 2007, the department allows a hospital with this dual status to receive distributions from the TCF; or

(iii) Any facility for follow-up services related to the qualifying trauma incident but provided to the client after the client has been discharged from the initial hospitalization for the qualifying injury.

(5) Distributions for an SFY are paid as follows:

(a) The first supplemental distribution from the TCF is made three to six months after the SFY begins;

(b) Subsequent distributions are made approximately every two to four months after the first distribution is made, except as described in subsection (c);

(c) The final distribution from the TCF for the same SFY is:

(i) Made after the end of the SFY;

(ii) Based on the SFY that the TCF designated amount relates to; and

(iii) Distributed based on each eligible hospital's percentage of the total payments made by the department to all designated trauma service centers for qualified trauma cases during the relevant SFY.

(6) For purposes of the supplemental distributions from the TCF, all of the following apply:

(a) The department considers a provider's request for a trauma claim adjustment only if the adjustment request is received by the department within three hundred sixty-five calendar days from the date of the initial trauma service. At its discretion, and with sufficient public notice, the department may adjust the deadline for submission and/or adjustment of trauma claims in response to budgetary program needs;

(b) Except as provided in subsection (6)(a) of this section, the deadline for making adjustments to a trauma claim is the same as the deadline for submitting the initial claim to the department as specified in WAC 388-502-0150(3). See WAC 388-502-0150 (11) and (12) for other time limits applicable to TCF claims;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the department in any biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

[Statutory Authority: RCW 70.168.040, 74.08.090, and 74.09.500. 10-12-013, § 388-550-5450, filed 5/21/10, effective 6/21/10. Statutory Authority: RCW 74.08.090, 74.09.160, 74.09.500, and 70.168.040. 08-08-065, § 388-550-5450, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.-090, 74.09.500. 07-14-090, § 388-550-5450, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5450, filed 3/30/06, effective 4/30/06; 04-19-113, § 388-550-5450, filed 9/21/04, effective 10/22/04.]

WAC 388-550-7050 OPPS—Definitions. The following definitions and abbreviations and those found in WAC 388-550-1050 apply to the department's outpatient prospective payment system (OPPS):

"Ambulatory payment classification (APC)" means a grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Budget target" means the amount of money appropriated by the legislature or through the department's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjustor" means a department-established component of the APC payment calculation applied to all payable ambulatory payment classifications (APCs) to allow the department to reach and not exceed the established budget target.

"Discount factor" means the percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Medical visit" means diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"National correct coding initiative (NCCI) is a national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the American Medical Associations's Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The centers for medicare and medicaid services (CMS) maintain NCCI policy. Information can be found at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

"National payment rate (NPR)" means a rate for a given procedure code, published by the centers for medicare

and medicaid (CMS), that does not include a state or location specific adjustment.

"Nationwide rate" see "national payment rate."

"NCCI edit" is a software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, department fee schedules, billing instructions, and other publications. The department has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards or department policy.

"Observation services" means services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Outpatient code editor (OCE)" means a software program that the department uses for classifying and editing claims in ambulatory payment classification (APC) based OPPS.

"Outpatient prospective payment system (OPPS)" means the payment system used by the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient prospective payment system (OPPS) conversion factor" see "outpatient prospective payment system (OPPS) rate."

"Outpatient prospective payment system (OPPS) rate" means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation.

"Pass-throughs" means certain drugs, devices, and biologicals, as identified by centers for medicare and medicaid services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

"Significant procedure" means a procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.

"Status indicator (SI)" means a code assigned to each medical procedure or service by the department that contributes to the selection of a payment method.

"SI" see **"status indicator."**

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530. 10-08-023, § 388-550-7050, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-7050, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500. 07-13-100, § 388-550-7050, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7050, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7200 OPPS—Billing requirements and payment method. (1) This section describes hospital provider billing requirements and the payment methods the department uses to pay for covered outpatient hospital services provided by hospitals not exempted from the outpatient prospective payment system (OPPS).

(2) Providers must bill according to national correct coding initiative (NCCI) standards. NCCI standards are based on:

(a) Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual;

(b) Current standards of medical and surgical coding practice;

(c) Input from specialty societies; and

(d) Analysis of current coding practices.

The centers for medicare and medicaid services (CMS) maintains NCCI policy.

AMBULATORY PAYMENT CLASSIFICATION (APC) METHOD

(3) The department uses the APC method when (CMS) has established a national payment rate to pay for covered services. The APC method is the primary payment methodology for OPPS. Examples of services paid by the APC methodology include, but are not limited to:

(a) Ancillary services;

(b) Medical visits;

(c) Nonpass-through drugs or devices;

(d) Observation services;

(e) Packaged services subject to separate payment when criteria are met;

(f) Pass-through drugs;

(g) Significant procedures that are not subject to multiple procedure discounting (except for dental-related services);

(h) Significant procedures that are subject to multiple procedure discounting; and

(i) Other services as identified by the department.

OPPS MAXIMUM ALLOWABLE FEE SCHEDULE

(4) The department uses the outpatient fee schedule published in the department's billing instructions to pay for covered:

(a) Services that are exempted from the APC payment methodology or services for which there are no established weight(s);

(b) Procedures that are on the CMS inpatient only list;

(c) Items, codes, and services that are not covered by medicare;

(d) Corneal tissue acquisition;

(e) Devices that are pass-throughs (see WAC 388-550-7050 for definition of pass-throughs); and

(f) Dental clinic services.

HOSPITAL OUTPATIENT RATE

(5) The department uses the hospital outpatient rate described in WAC 388-550-3900 and 388-550-4500 to pay for the services listed in subsection (4) of this section for which the department has not established a maximum allowable fee.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530. 10-08-023, § 388-550-7200, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-13-100, § 388-550-7200, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7200, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7300 OPPS—Payment limitations. (1) The department limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient fee schedule and published in the department's hospital billing instructions, subject to the following:

(a) To receive payment for services, providers must bill claims according to national correct coding initiative (NCCI) standards. See WAC 388-550-7200(2) for more information on NCCI standards. When a unit limit for services is not stated in the outpatient fee schedule, department pays for services according to the program's unit limits stated in applicable WAC and published issuances.

(b) Because multiple units for services may be factored into the ambulatory payment classification (APC) weight, department pays for services according to the unit limit stated in the outpatient fee schedule when the limit is not the same as the program's unit limit stated in applicable WAC and published issuances.

(2) The department does not pay separately for covered services that are packaged into the APC rates. These services are paid through the APC rates.

(3) The department:

(a) Limits surgical dental services payment to the ambulatory surgical services fee schedule and pays:

(i) The first surgical procedure at the applicable ambulatory surgery center group rate; and

(ii) The second surgical procedure at fifty percent of the ambulatory surgery center group rate.

(b) Considers all surgical procedures not identified in subsection (a) to be bundled.

(4) The department limits outpatient services billing to one claim per episode of care. If there are late charges, or if any line of the claim is denied, the department requires the entire claim to be adjusted.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.-530. 10-08-023, § 388-550-7300, filed 3/30/10, effective 4/30/10. Statutory Authority: RCW 74.08.090, 74.09.500. 07-13-100, § 388-550-7300, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7300, filed 10/1/04, effective 11/1/04.]

Chapter 388-551 WAC
ALTERNATIVES TO HOSPITAL SERVICES

WAC

388-551-1350 Discharges from hospice care.
388-551-2000 Home health services—General.
388-551-2010 Home health services—Definitions.
388-551-2020 Home health services—Eligible clients.
388-551-2030 Home health skilled services—Requirements.
388-551-2100 Home health services—Covered skilled nursing services.
388-551-2110 Home health services—Covered specialized therapy.
388-551-2120 Home health services—Covered aide services.
388-551-2125 Home health services—Delivered through telemedicine.
388-551-2130 Home health services—Noncovered services.
388-551-2200 Home health services—Eligible providers.
388-551-2210 Home health services—Provider requirements.
388-551-2220 Home health services—Provider payments.

WAC 388-551-1350 Discharges from hospice care. (1) A hospice agency may discharge a client from hospice care when the client:

(a) Is no longer certified for hospice care;

(b) Is no longer appropriate for hospice care; or

(c) The hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care (POC).

(2) At the time of a client's discharge, a hospice agency must:

(a) Within five working days, complete a medicaid hospice 5-day notification form (DSHS 13-746) and forward to the department's hospice program manager (see WAC 388-551-1400 for additional requirements), and a copy to the appropriate home and community services office (HCS) or community services office (CSO);

(b) Keep the discharge statement in the client's hospice record;

(c) Provide the client with a copy of the discharge statement; and

(d) Inform the client that the discharge statement must be:

(i) Presented with the client's current services card when obtaining medicaid covered healthcare services or supplies, or both; and

(ii) Used until the department removes the hospice restriction from the client's information available online at https://www.waproviderone.org.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-551-1350, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1350, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1350, filed 4/9/99, effective 5/10/99.]

WAC 388-551-2000 Home health services—General. The purpose of the department's home health program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in the client's residence, subject to the restrictions and limitations in this subchapter.

Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment. See chapters 388-515 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2000, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2000, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2000, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2010 Home health services—Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this subchapter:

"Acute care" means care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

"Brief skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

(1) An injection;

(2) Blood draw; or

(3) Placement of medications in containers.

"Chronic care" means long-term care for medically stable clients.

"Full skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a regis-

tered nurse, performs one or more of the following activities during a visit to a client:

(1) Observation;
(2) Assessment;
(3) Treatment;
(4) Teaching;
(5) Training;
(6) Management; and
(7) Evaluation.

"Home health agency" means an agency or organization certified under medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence.

"Home health aide" means an individual registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

"Home health aide services" means services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

"Home health skilled services" means skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a medicare-certified home health agency with a current provider number. See also WAC 388-551-2000.

"Long-term care" is a generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the department's aging and disability services administration (ADSA) through home and community services (HCS) or the division of developmental disabilities (DDD).

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both an ordering licensed practitioner and a home health agency provider. The plan describes the home health care to be provided at the client's residence. See WAC 388-551-2210.

"Residence" means a client's home or place of living. (See WAC 388-551-2030 (2)(g)(ii) for clients in residential facilities whose home health services are not covered through department's home health program.)

"Review period" means the three-month period the department assigns to a home health agency, based on the address of the agency's main office, during which the department reviews all claims submitted by that agency.

"Specialized therapy" means skilled therapy services provided to clients that include:

(1) Physical;
(2) Occupational; or
(3) Speech/audiology services.

(See WAC 388-551-2110.)

"Telemedicine" - For the purposes of WAC 388-551-2000 through 388-551-2220, means the use of telemonitoring to enhance the delivery of certain home health skilled nursing services through:

(1) The collection of clinical data and the transmission of such data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry; or

(2) The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2010, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2010, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2020 Home health services—Eligible clients. (1) Clients in the following fee-for-service programs are eligible to receive home health services subject to the limitations described in this chapter. Clients enrolled in a department-contracted managed care organization (MCO) receive all home health services through their designated plan.

(a) Categorically needy program (CNP);

(b) Limited casualty program - medically needy program (LCP-MNP); and

(c) Medical care services (MCS) under the following programs:

(i) General assistance - unemployable (GA-U); and

(ii) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (GA-W).

(2) The department does not cover home health services under the home health program for clients in the CNP-emergency medical only and LCP-MNP-emergency medical only programs. The department evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC 388-501-0165, and may cover up to two skilled nursing visits within the eligibility enrollment period if the following criteria are met:

(a) The client requires hospital care due to an emergent medical condition as described in WAC 388-500-0005; and

(b) The department authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2020, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2020, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2020, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2030 Home health skilled services—Requirements. (1) The department reimburses for covered home health skilled services provided to eligible clients, subject to the restrictions or limitations in this section and other applicable published WAC.

(2) Home health skilled services provided to eligible clients must:

(a) Meet the definition of "acute care" in WAC 388-551-2010.

(b) Provide for the treatment of an illness, injury, or disability.

(c) Be medically necessary as defined in WAC 388-500-0005.

(d) Be reasonable, based on the community standard of care, in amount, duration, and frequency.

(e) Be provided under a plan of care (POC), as defined in WAC 388-551-2010 and described in WAC 388-551-2210. Any statement in the POC must be supported by documentation in the client's medical records.

(f) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of an ordering licensed practitioner's office, clinic, or other outpatient setting. This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short-term basis.

(g) Be provided in the client's residence.

(i) The department does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client's place of residence.

(ii) Clients in residential facilities contracted with the state and paid by other programs such as home and community programs to provide limited skilled nursing services, are not eligible for department-funded limited skilled nursing services unless the services are prior authorized under the provisions of WAC 388-501-0165.

(h) Be provided by:

(i) A home health agency that is Title XVIII (medicare) certified;

(ii) A registered nurse (RN) prior authorized by the department when no home health agency exists in the area a client resides; or

(iii) An RN authorized by the department when the RN is unable to contract with a medicare-certified home health agency.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2030, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2030, filed 7/15/02, effective 8/15/02.]

WAC 388-551-2100 Home health services—Covered skilled nursing services. (1) The department covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. The department evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165.

(2) The department covers the following home health acute care skilled nursing services, subject to the limitations in this section:

(a) Full skilled nursing services that require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, if the services involve one or more of the following:

(i) Observation;

(ii) Assessment;

(iii) Treatment;

(iv) Teaching;

(v) Training;

(vi) Management; and

(vii) Evaluation.

(b) A brief skilled nursing visit if only one of the following activities is performed during the visit:

(i) An injection;

(ii) Blood draw; or

(iii) Placement of medications in containers (e.g., envelopes, cups, medisets).

(c) Home infusion therapy only if the client:

(i) Is willing and capable of learning and managing the client's infusion care; or

(ii) Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

(d) Infant phototherapy for an infant diagnosed with hyperbilirubinemia:

(i) When provided by a department-approved infant phototherapy agency; and

(ii) For up to five skilled nursing visits per infant.

(e) Limited high-risk obstetrical services:

(i) For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;

(ii) For up to three home health visits per pregnancy if:

(A) Enrollment in or referral to the following providers of first steps has been verified:

(I) Maternity support services (MSS); or

(II) Maternity case management (MCM); and

(B) The visits are provided by a registered nurse who has either:

(I) National perinatal certification; or

(II) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

(3) The department limits skilled nursing visits provided to eligible clients to two per day.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2100, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2100, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2100, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2110 Home health services—Covered specialized therapy. (1) The department limits specialized therapy visits to one per client, per day, per type of specialized therapy. Specialized therapy is defined in WAC 388-551-2010.

(2) The department does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2110, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2110, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2110, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2120 Home health services—Covered aide services. (1) The department pays for one home health aide visit, per client per day.

(2) The department reimburses for home health aide services, as defined in WAC 388-551-2010, only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

(a) Skilled nursing services; or

(b) Specialized therapy services.

(3) The department covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2120, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2120, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2120, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2125 Home health services—Delivered through telemedicine. (1) The department covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a diagnosis(es) where there is a high risk of sudden change in clinical status which could compromise health outcomes.

(2) The department pays for one telemedicine interaction, per eligible client, per day based on the ordering licensed practitioner's home health plan of care.

(3) To receive payment for the delivery of home health services through telemedicine, the services must involve:

(a) An assessment, problem identification, and evaluation which includes:

(i) Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care; and

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;

(iv) Coordination of care with the ordering licensed practitioner regarding telemedicine findings;

(v) Coordination and referral to other medical providers as needed; and

(vi) Referral to the emergency room as needed.

(4) The department does not require prior authorization for the delivery of home health services through telemedicine.

(5) The department does not pay for the purchase, rental, or repair of telemedicine equipment.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2125, filed 5/3/10, effective 6/3/10.]

WAC 388-551-2130 Home health services—Noncovered services. (1) The department does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services' aging and disability services administration (ADSA).

(i) The department considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ADSA to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, the department may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WACs.

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 388-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients in the following programs:

(i) CNP - emergency medical only; and

(ii) LCP-MNP - emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy and/or home health aide visit per day.

(l) HRSA does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

(m) Home health visits made without a written licensed practitioner's order, unless the verbal order is:

(i) Documented prior to the visit; and

(ii) The document is signed by the ordering licensed practitioner within forty-five days of the order being given.

(2) HRSA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) HRSA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2130, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-551-2130, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2130, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2130, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2200 Home health services—Eligible providers. The following may contract with the department to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (medicare) certified;

(b) Is department of health (DOH) licensed as a home health agency;

(c) Submits a completed, signed core provider agreement to the department; and

(d) Is assigned a provider number.

(2) A registered nurse (RN) who:

(a) Is prior authorized by the department to provide intermittent nursing services when no home health agency exists in the area a client resides;

(b) Is unable to contract with a medicare-certified home health agency;

(c) Submits a completed, signed core provider agreement to the department; and

(d) Is assigned a provider number.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2200, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2200, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2200, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2210 Home health services—Provider requirements. For any delivered home health service to be payable, the department requires home health providers to develop and implement an individualized plan of care (POC) for the client.

(1) The POC must:

(a) Be documented in writing and be located in the client's home health medical record;

(b) Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;

(c) Reflect the ordering licensed practitioner's orders and client's current health status;

(d) Contain specific goals and treatment plans;

(e) Be reviewed and revised by an ordering licensed practitioner at least every sixty calendar days, signed by the ordering licensed practitioner within forty-five days of the verbal order, and returned to the home health agency's file; and

(f) Be available to department staff or its designated contractor(s) on request.

(2) The provider must include in the POC all of the following:

(a) The client's name, date of birth, and address (to include name of residential care facility, if applicable);

(b) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for home health services) or the diagnosis that is the reason for the visit frequency;

(c) All secondary medical diagnoses, including date(s) of onset or exacerbation;

(d) The prognosis;

(e) The type(s) of equipment required, including telemedicine as appropriate;

(f) A description of each planned service and goals related to the services provided;

(g) Specific procedures and modalities;

(h) A description of the client's mental status;

(i) A description of the client's rehabilitation potential;

(j) A list of permitted activities;

(k) A list of safety measures taken on behalf of the client; and

(l) A list of medications which indicates:

(i) Any new prescription; and

(ii) Which medications are changed for dosage or route of administration.

(3) The provider must include in or attach to the POC:

(a) A description of the client's functional limits and the effects;

(b) Documentation that justifies why the medical services should be provided in the client's residence instead of an ordering licensed practitioner's office, clinic, or other outpatient setting;

(c) Significant clinical findings;

(d) Dates of recent hospitalization;

(e) Notification to the DSHS case manager of admittance;

(f) A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge; and

(g) Order for the delivery of home health services through telemedicine, as appropriate.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

(a) Visit notes for every billed visit;

(b) Supervisory visits for home health aide services as described in WAC 388-551-2120(3);

(c) All medications administered and treatments provided;

(d) All licensed practitioner's orders, new orders, and change orders, with notation that the order was received prior to treatment;

(e) Signed licensed practitioner's new orders and change orders;

(f) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;

(g) Interdisciplinary and multidisciplinary team communications;

(h) Inter-agency and intra-agency referrals;

(i) Medical tests and results;

(j) Pertinent medical history; and

(k) Notations and charting with signature and title of writer.

(5) The provider must document at least the following in the client's medical record:

(a) Skilled interventions per the POC;

(b) Client response to the POC:

(c) Any clinical change in client status;

(d) Follow-up interventions specific to a change in status with significant clinical findings;

(e) Any communications with the attending ordering licensed practitioner; and

(f) Telemedicine findings, as appropriate.

(6) The provider must include the following documentation in the client's visit notes when appropriate:

(a) Any teaching, assessment, management, evaluation, client compliance, and client response;

(b) Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;

(c) If a client's wound is not healing, the client's ordering licensed practitioner has been notified, the client's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist; and

(d) The client's physical system assessment as identified in the POC.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2210, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2210, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2220 Home health services—Provider payments. (1) In order to be reimbursed, the home health provider must bill the department according to the conditions of payment under WAC 388-502-0150 and other issuances.

(2) Payment to home health providers is:

(a) A set rate per visit for each discipline provided to a client;

(b) Based on the county location of the providing home health agency; and

(c) Updated by general vendor rate changes.

(3) For clients eligible for both medicaid and medicare, the department may pay for services described in this chapter only when medicare does not cover those services. The maximum payment for each service is medicaid's maximum payment.

(4) Providers must submit documentation to the department during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 388-551-2210.

(5) After the department receives the documentation, the department's medical director or designee reviews the client's medical records for program compliance and quality of care.

(6) The department may take back or deny payment for any insufficiently documented home health care service when the department's medical director or designee determines that:

(a) The service did not meet the conditions described in WAC 388-550-2030; or

(b) The service was not in compliance with program policy.

(7) Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

[Statutory Authority: RCW 74.08.090, chapter 74.09 RCW, and 2009 c 326. 10-10-087, § 388-551-2220, filed 5/3/10, effective 6/3/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2220, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]

Chapter 388-553 WAC

HOME INFUSION THERAPY/PARENTERAL NUTRITION PROGRAM

WAC

388-553-100 Home infusion therapy/parenteral nutrition program—General.

388-553-300 Home infusion therapy/parenteral nutrition program—Client eligibility and assignment.

388-553-400 Home infusion therapy/parenteral nutrition program—Provider requirements.

WAC 388-553-100 Home infusion therapy/parenteral nutrition program—General. The department's home infusion therapy/parenteral nutrition program provides the supplies and equipment necessary for parenteral infusion of therapeutic agents to medical assistance clients. An eligible client receives equipment, supplies, and parenteral administration of therapeutic agents in a qualified setting to improve or sustain the client's health.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-553-100, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-530. 04-11-007, § 388-553-100, filed 5/5/04, effective 6/5/04.]

WAC 388-553-300 Home infusion therapy/parenteral nutrition program—Client eligibility and assignment. (1) Clients in the following medical assistance programs are eligible to receive home infusion therapy and parenteral nutrition, subject to the limitations and restrictions in this section and other applicable WAC:

(a) Categorically needy program (CNP);

(b) Categorically needy program - Children's health insurance program (CNP-CHIP);

(c) General assistance - Unemployable (GA-U); and

(d) Limited casualty program - Medically needy program (LCP-MNP).

(2) Clients enrolled in a department-contracted managed care organization (MCO) are eligible for home infusion therapy and parenteral nutrition through that plan.

(3) Clients eligible for home health program services may receive home infusion related services according to WAC 388-551-2000 through 388-551-3000.

(4) To receive home infusion therapy, a client must:

(a) Have a written physician order for all solutions and medications to be administered.

(b) Be able to manage their infusion in one of the following ways:

(i) Independently;

(ii) With a volunteer caregiver who can manage the infusion; or

(iii) By choosing to self-direct the infusion with a paid caregiver (see WAC 388-71-0580).

(c) Be clinically stable and have a condition that does not warrant hospitalization.

(d) Agree to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply.

(e) Consent, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent.

(f) Reside in a residence that has adequate accommodations for administering infusion therapy including:

(i) Running water;

(ii) Electricity;

(iii) Telephone access; and

(iv) Receptacles for proper storage and disposal of drugs and drug products.

(5) To receive parenteral nutrition, a client must meet the conditions in subsection (4) of this section and:

(a) Have one of the following that prevents oral or enteral intake to meet the client's nutritional needs:

(i) Hyperemesis gravidarum; or

(ii) An impairment involving the gastrointestinal tract that lasts three months or longer.

(b) Be unresponsive to medical interventions other than parenteral nutrition; and

(c) Be unable to maintain weight or strength.

(6) A client who has a functioning gastrointestinal tract is not eligible for parenteral nutrition program services when the need for parenteral nutrition is only due to:

(a) A swallowing disorder;

(b) Gastrointestinal defect that is not permanent unless the client meets the criteria in subsection (7) of this section;

(c) A psychological disorder (such as depression) that impairs food intake;

(d) A cognitive disorder (such as dementia) that impairs food intake;

(e) A physical disorder (such as cardiac or respiratory disease) that impairs food intake;

(f) A side effect of medication; or

(g) Renal failure or dialysis, or both.

(7) A client with a gastrointestinal impairment that is expected to last less than three months is eligible for parenteral nutrition only if:

(a) The client's physician or appropriate medial [medical] provider has documented in the client's medical record the gastrointestinal impairment is expected to last less than three months;

(b) The client meets all the criteria in subsection (4) of this section;

(c) The client has a written physician order that documents the client is unable to receive oral or tube feedings; and

(d) It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

(8) A client is eligible to receive intradialytic parenteral nutrition (IDPN) solutions when:

(a) The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis; and

(b) The client meets the criteria in subsection (4) and (5) of this section and other applicable WAC.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-553-300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-530. 04-11-007, § 388-553-300, filed 5/5/04, effective 6/5/04.]

WAC 388-553-400 Home infusion therapy/parenteral nutrition program—Provider requirements. (1) Eligible providers of home infusion supplies and equipment and parenteral nutrition solutions must:

(a) Have a signed core provider agreement with the department; and

(b) Be one of the following provider types:

(i) Pharmacy provider;

(ii) Durable medical equipment (DME) provider; or

(iii) Infusion therapy provider.

(2) The department pays eligible providers for home infusion supplies and equipment and parenteral nutrition solutions only when the providers:

(a) Are able to provide home infusion therapy within their scope of practice;

(b) Have evaluated each client in collaboration with the client's physician, pharmacist, or nurse to determine whether home infusion therapy/parenteral nutrition is an appropriate course of action;

(c) Have determined that the therapies prescribed and the client's needs for care can be safely met;

(d) Have assessed the client and obtained a written physician order for all solutions and medications administered to the client in the client's residence or in a dialysis center through intravenous, epidural, subcutaneous, or intrathecal routes;

(e) Meet the requirements in WAC 388-502-0020, including keeping legible, accurate and complete client charts, and providing the following documentation in the client's medical file:

(i) For a client receiving infusion therapy, the file must contain:

(A) A copy of the written prescription for the therapy;

(B) The client's age, height, and weight; and

(C) The medical necessity for the specific home infusion service.

(ii) For a client receiving parenteral nutrition, the file must contain:

(A) All the information listed in (e)(i) of this subsection;

(B) Oral or enteral feeding trials and outcomes, if applicable;

(C) Duration of gastrointestinal impairment; and

(D) The monitoring and reviewing of the client's lab values:

(I) At the initiation of therapy;

(II) At least once per month; and

(III) When the client and/or the client's lab results are unstable.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-553-400, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.-530. 04-11-007, § 388-553-400, filed 5/5/04, effective 6/5/04.]

Chapter 388-556 WAC
MEDICAL CARE—OTHER SERVICES PROVIDED

WAC

388-556-0200 Chiropractic services for children.
388-556-0600 Mental health services.

WAC 388-556-0200 Chiropractic services for children. (1) The department will pay only for chiropractic services:

(a) For clients who are:

(i) Under twenty-one years of age; and

(ii) Referred by a screening provider under the healthy kids/early and periodic screening, diagnosis, and treatment (EPSDT) program.

(b) That are:

(i) Medically necessary, safe, effective, and not experimental;

(ii) Provided by a chiropractor licensed in the state where services are provided; and

(iii) Within the scope of the chiropractor's license.

(c) Limited to:

(i) Chiropractic manipulative treatments of the spine; and

(ii) X rays of the spine.

(2) Chiropractic services are paid according to fees established by the department using methodology set forth in WAC 388-531-1850.

[Statutory Authority: RCW 74.08.090. 10-19-057, § 388-556-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.035. 00-16-031, § 388-556-0200, filed 7/24/00, effective 8/24/00.]

WAC 388-556-0600 Mental health services. Mental health-related services are available to eligible clients under chapter 388-865 WAC and WAC 388-531-1400.

[Statutory Authority: RCW 74.08.090. 10-02-100, § 388-556-0600, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 74.08.090, 74.09.530, 71.24.035. 00-24-053, § 388-556-0600, filed 11/30/00, effective 12/31/00.]

Chapter 388-816 WAC
CERTIFICATION REQUIREMENTS FOR PROBLEM AND PATHOLOGICAL GAMBLING TREATMENT PROGRAM

WAC

388-816-0001 What is the purpose of this chapter?
388-816-0005 What definitions are important throughout this chapter?
388-816-0010 What problem and pathological gambling treatment programs are certified by the department?
388-816-0015 How do I apply for certification as a new problem and pathological gambling treatment program?
388-816-0020 How do currently certified or licensed agencies apply for added service?
388-816-0025 What are the requirements for treatment program facilities?
388-816-0030 How does the department conduct an examination of facilities?
388-816-0035 How does the department determine disqualification or denial of an application?
388-816-0040 What happens after I make application for certification?
388-816-0045 How do I apply for an exemption?
388-816-0070 What do I need to do to maintain program certification?
388-816-0075 What do I need to do for a change in ownership?
388-816-0080 What do I do to relocate or remodel a facility?
388-816-0085 How does the department assess penalties?
388-816-0090 How does the department cancel certification?
388-816-0095 How does the department suspend or revoke certification?
388-816-0100 What is the prehearing, hearing and appeal process?
388-816-0105 What are the requirements for the governing body of the program?
388-816-0110 What are the key responsibilities required of a program administrator?
388-816-0115 What must be included in a program administrative manual?
388-816-0120 What must be included in a treatment program personnel manual?
388-816-0125 What are treatment program personnel file requirements?
388-816-0130 What are the minimum qualifications for clinical staff members providing problem and pathological gambling treatment?
388-816-0135 What must be included in the treatment program clinical manual?
388-816-0140 What are clients' rights requirements in certified treatment programs?
388-816-0145 What are the requirements for problem and pathological gambling assessments?
388-816-0150 What are the requirements for treatment, continuing care, transfer, and discharge plans?
388-816-0155 What are the requirements for a client record system?
388-816-0160 What are the requirements for client record content?
388-816-0165 What are the requirements for reporting client noncompliance?
388-816-0170 What are the requirements for outcomes evaluation?
388-816-0175 What are the requirements for outpatient services?
388-816-0180 What are the requirements for providing off-site problem and pathological gambling treatment services?

WAC 388-816-0001 What is the purpose of this chapter? These rules describe the standards and processes necessary to be a certified problem and pathological gambling treatment program. The rules have been adopted under the authority and purposes of the following chapters of law.

(1) Chapter 43.20A RCW, Department of social and health services.

(2) Chapter 49.60 RCW, Discrimination—Human rights commission.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0001, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0005 What definitions are important throughout this chapter? "Added service" means the adding of certification for problem and pathological gambling treatment levels of care to an existing agency certified under chapter 388-805 or 388-865 WAC at an approved location.

"Administrator" means the person designated responsible for the operation of the certified treatment program.

"Adult" means a person eighteen years of age or older.

"Assessment" means the ongoing process of identifying a diagnosis and determining the care needed by the problem gambling client. The assessment includes the requirements described in WAC 388-816-0145 in order to develop a treatment plan.

"Authenticated" means written, permanent verification of an entry in a client treatment record by an individual, by means of an original signature including first initial, last name, and professional designation or job title, or initials of the name if the file includes an authentication record, and the date of the entry. If client records are maintained electronically, unique electronic passwords, biophysical or passcard equipment are acceptable methods of authentication.

"Authentication record" means a document that is part of a client's treatment record, with legible identification of all persons initialing entries in the treatment record, and includes:

(1) Full printed name;

(2) Signature including the first initial and last name; and

(3) Initials and abbreviations indicating professional designation or job title.

"Case management" means services provided to assist the client in gaining access to needed medical, social, educational, and other services. Services include case planning, case consultation, and referral, and other support services for the purpose of engaging and retaining or maintaining clients in treatment.

"Certified treatment program" means a legally operated entity certified by the department to provide problem and pathological gambling treatment services. The components of a treatment program are:

(1) Legal entity/owner;

(2) Facility; and

(3) Staff and services.

"Change in ownership" means one of the following conditions:

(1) When the ownership of a certified problem and pathological gambling treatment program changes from one distinct legal owner to another distinct legal owner;

(2) When the type of business changes from one type to another such as, from a sole proprietorship to a corporation; or

(3) When the current ownership takes on a new owner of five percent or more of the organizational assets.

"Client" means an individual receiving problem or pathological gambling treatment services from a certified program.

"Clinical staff member" means an individual credentialed by the department of health in a counseling profession per chapter 18.19, 18.83, or 18.225 RCW.

"Criminal background check" means a search by the Washington state patrol for any record of convictions or civil adjudication related to crimes against children or other persons, including developmentally disabled and vulnerable adults, per RCW 43.43.830 through 43.43.842 relating to the Washington state patrol.

"Critical incident" includes:

(1) Death of a client;

(2) Serious injury;

(3) Sexual assault of clients, staff members, or public citizens on the facility premises;

(4) Abuse or neglect of an adolescent or vulnerable adult client by another client or program staff member on facility premises;

(5) A natural disaster presenting a threat to facility operation or client safety;

(6) A bomb threat; a break in or theft of client identifying information; and

(7) Suicide attempt at the facility.

"Department" means the Washington state department of social and health services.

"Disability, a person with" means a person whom:

(1) Has a physical or mental impairment that substantially limits one or more major life activities of the person;

(2) Has a record of such an impairment; or

(3) Is regarded as having such an impairment.

"DSM-IV TR" means diagnostic and statistical manual of mental disorders, fourth edition text revision, published by the American Psychiatric Association.

"Essential requirement" means a critical element of problem and pathological gambling treatment services that must be present in order to provide effective treatment.

"Financial evaluation" means the total of a client's monthly financial obligations including gambling debts.

"Governing body" means the officers, board of directors or trustees of a corporation or limited liability company who make up the body for the purpose of administering the problem or pathological gambling program.

"Outcomes evaluation" means a system for determining the effectiveness of results achieved by clients during or following service delivery, and client satisfaction with those results for the purpose of program improvement.

"Pathological gambling" means a mental disorder characterized by loss of control over gambling, progression in and preoccupation with gambling and in obtaining money to gamble and continuation of gambling despite adverse consequences.

"Problem gambling" means an earlier stage of pathological gambling which compromises, disrupts, or damages family or personal relationships or vocational pursuits.

"Progress notes" are a permanent record of ongoing assessments of a client's participation in and response to treatment, and progress in recovery.

"Qualified personnel" means trained, qualified staff who meet appropriate legal, licensing, certification, and registration requirements.

"Relocation" means change in location from one office space to a new office space, or moving from one office building to another.

"Remodeling" means expansion of existing office space to additional office space at the same address, or remodeling of interior walls and space within existing office space.

"Summary suspension" means an immediate suspension of certification, per RCW 34.05.422(4), by the department pending administrative proceedings for suspension, revocation, or other actions deemed necessary by the department.

"Suspend" means termination of the department's certification of a program's treatment services for a specified period or until specific conditions have been met and the department notifies the program of reinstatement.

"Treatment plan review" means a review of active problems on the client's individualized treatment plan, the need to address new problems, and client placement.

"Vulnerable adult" means a person who lacks the functional, mental, or physical ability to care for oneself.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0005, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0010 What problem and pathological gambling treatment programs are certified by the department? The department certifies problem and pathological gambling treatment programs which includes diagnostic screening and assessment, individual, group, couples and family counseling and case management.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0010, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0015 How do I apply for certification as a new problem and pathological gambling treatment program? (1) A potential new problem and pathological gambling treatment program, referred to as applicant, seeking certification as described under WAC 388-816-0010, must request from the department an application packet of information on how to become a certified problem and pathological gambling treatment program.

(2) The applicant must submit a completed application to the department that includes:

(a) If the applicant is a sole proprietor: The name and address of the applicant, and a statement of sole proprietorship;

(b) If the applicant is a partnership: The name and address of every partner, and a copy of the written partnership agreement;

(c) If the applicant is a limited liability corporation: The name and addresses of its officers and any owner of five percent or more of the organizational assets, and a copy of the certificate of formation issued by the state of Washington, secretary of state;

(d) If the applicant is a corporation: The names and addresses of its officers, board of directors and trustees, and any owner of five percent or more of the organizational assets, and a copy of the corporate articles of incorporation and bylaws;

(e) A copy of the master business license authorizing the organization to do business in Washington state;

(f) The Social Security number or Federal Employer Identification Number for the governing organization or person;

(g) The name and job description of the individual administrator appointed by the governing body under whose management or supervision the services will be provided;

(h) A copy of the report of findings from a criminal background check of any owner of five percent or more of the organizational assets and the administrator;

(i) Additional disclosure statements or background inquiries if the department has reason to believe that offenses specified under RCW 43.43.830, have occurred since completion of the original application;

(j) The physical location of the facility where services will be provided including, in the case of a location known only by postal route and box numbers, and the street address;

(k) Program facility requirements as set forth in WAC 388-816-0025;

(l) Policy and procedure manuals specific to the program at the proposed site, and meet the manual requirements described later in this regulation, including the:

(i) Administrative manual;

(ii) Personnel manual; and

(iii) Clinical manual.

(m) Sample client records for the treatment service applied for; and

(n) Evidence of sufficient qualified staff to deliver services.

(3) The program owner or legal representative must:

(a) Sign the completed application form and submit the original to the department; and

(b) Report any changes occurring during the certification process.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0015, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0020 How do currently certified or licensed agencies apply for added service? Treatment programs certified or licensed by the department through either chapter 388-805 or 388-865 WAC must apply for an added service by submitting an abbreviated application, including:

(1) The name of the individual administrator providing management or supervision of the program;

(2) A written declaration that a current copy of the agency policy and procedure manual will be maintained for the added service and that the manual has been revised to accommodate the differences in business and clinical practices at that site;

(3) An organization chart, showing the relationship of the added service to the main organization, job titles, and lines of authority;

(4) Evidence of sufficient qualified staff to deliver services for the added service; and

(5) Evidence of meeting the requirements of:

(a) WAC 388-816-0015 (2)(h) through (l), (2)(n), and (3);

(b) WAC 388-816-0145;

(c) WAC 388-816-0150;

(d) WAC 388-816-0160;

(e) WAC 388-816-0170; and

(f) WAC 388-816-0175.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0020, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0025 What are the requirements for treatment program facilities? (1) For each treatment program facility, the applicant must include a floor plan showing the dimensions and intended use of each room that includes the location of:

(a) Floor to ceiling walls;

(b) Windows and doors;

(c) Restrooms;

(d) Areas serving as confidential counseling rooms;

(e) Confidential client records storage; and

(f) Other therapy and recreation areas and rooms.

(2) The applicant must submit a completed facility accessibility self-evaluation form.

(3) The administrator must ensure the treatment site:

(a) Is accessible to a person with a disability;

(b) Has a reception area separate from therapy areas;

(c) Has adequate private space for personal consultation with a client, staff charting, and therapeutic and social activities, as appropriate;

(d) Has secure storage of active and closed confidential client records;

(e) Has current fire inspection approval;

(f) Has facilities and furnishings that are kept clean and in good repair;

(g) Has adequate lighting, heating, and ventilation; and

(h) Has separate and secure storage of toxic substances, which are used only by staff or supervised persons.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0025, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0030 How does the department conduct an examination of facilities? The department must conduct an on-site examination of each new applicant's facility. The department must determine if the applicant's facility is:

(1) Substantially as described.

(2) Suitable for the purposes intended.

(3) Not a personal residence.

(4) Approved as meeting all building and safety requirements.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0030, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0035 How does the department determine disqualification or denial of an application? The department must consider the ability of each person named in the application to operate in accordance with this chapter before the department grants or renews certification of problem and pathological gambling service.

(1) The department must deny an applicant's certification when any of the following conditions occurred and was not satisfactorily resolved, or when any owner or administrator:

(a) Had a license or certification for a health care agency denied, revoked, or suspended;

(b) Was convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse;

(c) Obtained or attempted to obtain a health provider license, certification, or registration by fraudulent means or misrepresentation;

(d) Committed, permitted, aided, or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180;

(e) Demonstrated cruelty, abuse, negligence, misconduct, or indifference to the welfare of a client or displayed acts of discrimination;

(f) Misappropriated client property or resources;

(g) Failed to meet financial obligations or contracted service commitments that affect client care;

(h) Has a history of noncompliance with state or federal regulations in an agency with which the applicant has been affiliated;

(i) Knowingly, or with reason to know, made a false statement of fact or failed to submit necessary information in:

(i) The application or materials attached; and

(ii) Any matter under department investigation.

(j) Refused to allow the department access to records, files, books, or portions of the premises relating to operation of the problem and pathological gambling program service;

(k) Willfully interfered with the preservation of material information or attempted to impede the work of an authorized department representative;

(l) Is in violation of any provision of RCW 43.20A.890; or

(m) Does not meet criminal background check requirements.

(2) The department may deny certification when an applicant:

(a) Fails to provide satisfactory application materials; or

(b) Advertises itself as certified when certification has not been granted, or has been revoked or canceled.

(3) The applicant may appeal department decisions in accord with chapter 34.05 RCW, the Washington Administrative Procedure Act and chapter 388-02 WAC.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0035, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0040 What happens after I make application for certification? (1) The department may grant a treatment program applicant initial certification after a review of application materials and an on-site visit confirms the applicant has the capacity to operate in compliance with this chapter.

(2) A treatment program's failure to meet and maintain conditions of the initial certification may result in suspension of certification.

(3) An initial certificate of approval may be issued for up to one year.

(4) The treatment program must post the certificate in a conspicuous place on the premises.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0040, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0045 How do I apply for an exemption? (1) The department may grant an exemption from compliance with specific requirements in this WAC chapter if the exemption does not violate:

(a) An existing federal or state law; or

(b) An existing tribal law.

(2) Treatment programs must submit a signed letter requesting the exemption to the Supervisor, Certification Section, Division of Behavioral Health and Recovery, P.O. Box 45330, Olympia, WA 98504-5330. The program must assure the exemption request does not:

(a) Jeopardize the safety, health, or treatment of clients; or

(b) Impede fair competition of another program.

(3) The department must approve or deny all exemption requests in writing.

(4) The department and the treatment program must maintain a copy of the decision.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0045, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0070 What do I need to do to maintain program certification? Certificates are effective for one year from the date of issuance. A service program's continued certification and renewal is contingent upon:

(1) Completion of an annual declaration of certification;

(2) Providing the essential requirements for problem and pathological gambling treatment, including the following elements:

(a) Treatment process:

(i) Assessments, as described in WAC 388-816-0145;

(ii) Treatment planning, as described in WAC 388-816-0150 (2)(a) and 388-816-0160(8);

(iii) Documenting client progress, as described in WAC 388-816-0150 (1)(b) and 388-816-0160(10);

(iv) Treatment plan reviews and updates, as described in WAC 388-816-0160(11) and 388-816-0175 (1)(d)(i) and (ii);

(v) Continuing care, and discharge planning, as described in WAC 388-816-0150 (2)(d), 388-816-0150 (6) and (7), and 388-816-0160(14);

(vi) Conducting individual and group counseling, as described in WAC 388-816-0150 (2)(b) and 388-816-0160(10).

(b) Staffing, to include providing sufficient qualified personnel for the care of clients as described in WAC 388-816-0130.

(c) Facility, to include providing sufficient facilities, equipment, and supplies for the care and safety of clients as described in WAC 388-816-0105 (5) and (6).

(3) Findings during periodic on-site surveys and complaint investigations to determine the program's compliance with this chapter. During on-site surveys and complaint investigations, program representatives must cooperate with department representatives to:

(a) Examine any part of the facility at reasonable times and as needed;

(b) Review and evaluate records, including client clinical records, personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with clients and staff members.

(4) The program must post the notice of a scheduled department on-site survey in a conspicuous place accessible to clients and staff.

(5) The program must correct compliance deficiencies found at such surveys immediately or as agreed by a plan of correction approved by the department.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0070, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0075 What do I need to do for a change in ownership? (1) When a certified problem and pathological gambling treatment program plans a change in ownership, the current service program must submit a change in ownership application form sixty or more days before the proposed effective date of ownership change.

(2) The current program must include the following information with the application:

(a) Name and address of each new prospective owner of five percent or more of the organizational assets as required by WAC 388-816-0015 (2)(a) through (d);

(b) Current and proposed name (if applicable) of the service provider;

(c) Date of the proposed transaction;

(d) A copy of the transfer agreement between the outgoing and incoming owner(s);

(e) If a corporation, the names and addresses of the proposed responsible officers or partners;

(f) A statement regarding the disposition and management of client records, as described under 45 CFR, Part 160 through 164, and WAC 388-816-0155; and

(g) A copy of the report of findings from a criminal background check of any new owner of five percent or more of the organizational assets and new administrator when applicable.

(3) The department must determine which, if any, WAC 388-816-0015 or 388-816-0020 requirements apply to the potential new program, depending on the extent of ownership and operational changes.

(4) The department may grant certification to the new owner when the new owner:

(a) Successfully completes the application process; and

(b) Ensures continuation of compliance with rules of this chapter and implementation of plans of correction for deficiencies relating to this chapter, when applicable.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0075, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0080 What do I do to relocate or remodel a facility? (1) When a certified problem or pathological gambling treatment program plans to relocate or change the physical structure of a facility in a manner that affects client care, the program must:

(a) Submit a completed program relocation approval request form, or a request for approval in writing if remodeling, sixty or more days before the proposed date of relocation or change.

(b) Submit a sample floor plan that includes information identified in WAC 388-816-0025.

(c) Submit a completed facility accessibility self-evaluation form.

(d) Provide for department examination of the premises before approval, as described under WAC 388-816-0030.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0080, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0085 How does the department assess penalties? When the department determines that a treatment program fails to comply with requirements of this chapter, the department may cease referrals of new clients who are recipients of services funded by state or federal funds.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0085, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0090 How does the department cancel certification? The department may cancel certification if the treatment program:

(1) Stops providing the certified service.

(2) Voluntarily cancels certification.

(3) Changes ownership without prior notification and approval.

(4) Relocates without prior notification and approval.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0090, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0095 How does the department suspend or revoke certification? (1) The department must suspend or revoke a treatment program's certification when a disqualifying situation described under WAC 388-816-0035 applies to a current program.

(2) The department may suspend or revoke a program's certification when any of the following deficiencies or circumstances occur:

(a) A program fails to provide the essential requirements of problem or pathological gambling treatment as described in WAC 388-816-0070(2), and one or more of the following conditions occur:

(i) Violation of a rule threatens or results in harm to a client;

(ii) A reasonably prudent program should have been aware of a condition resulting in significant violation of a law or rule;

(iii) A program failed to investigate or take corrective or preventive action to deal with a suspected or identified client care problem;

(iv) Noncompliance occurs repeatedly in the same or similar areas; or

(v) There is an inability to attain compliance with laws or rules within a reasonable period of time.

(b) The program fails to submit an acceptable and timely plan of correction for cited deficiencies; or

(c) The program fails to correct cited deficiencies.

(3) The department may suspend certification upon receipt of a written request from the program. Programs requesting voluntary suspension must submit a written request for reinstatement of certification within one year from the effective date of the suspension. The department will review the request for reinstatement, determine if the program is able to operate in compliance with certification requirements, and notify the program of the results of the review for reinstatement.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0095, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0100 What is the prehearing, hearing and appeal process? (1) In case of involuntary certification cancellation, suspension, or revocation of the certification, or a penalty for noncompliance, the department must:

(a) Notify the treatment program of any action to be taken; and

(b) Inform the program of prehearing and dispute conferences, hearing, and appeal rights under chapter 388-02 WAC.

(2) The department may order a summary suspension of the program's certification pending completion of the appeal process when the preservation of public health, safety, or welfare requires emergency action.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0100, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0105 What are the requirements for the governing body of the program? In treatment programs not certified or licensed under chapter 388-805 or 388-865 WAC, a governing body, legally responsible for the conduct and quality of services provided, must:

(1) Appoint an administrator responsible for the day-to-day operation of the program.

(2) Maintain a current job description for the administrator including the administrator's authority and duties.

(3) Notify the department within thirty days, of changes of the program administrator.

(4) Provide personnel, facilities, equipment, and supplies necessary for the safety and care of clients.

(5) Ensure:

(a) Safety of clients and staff;

(b) Maintenance and operation of the facility; and

(c) The administration and operation of the program is in compliance with:

(i) Chapter 388-816 WAC requirements;

(ii) Applicable federal, state, tribal, and local laws and rules; and

(iii) Applicable federal, state, tribal, and local licenses, permits, and approvals.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0105, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0110 What are the key responsibilities required of a program administrator? In treatment programs not certified or licensed under chapter 388-805 or 388-865 WAC, the administrator must:

(1) Be responsible for the day-to-day operation of the certified treatment service, including:

(a) All administrative matters;

(b) Client care services; and

(c) Meeting all applicable rules and ethical standards.

(2) Delegate the authority and responsibility to act in the administrator's behalf when the administrator is not on duty or on call.

(3) Ensure administrative, personnel, and clinical policy and procedure manuals:

(a) Are developed and adhered to; and

(b) Are reviewed and revised as necessary, and at least annually.

(4) Employ sufficient qualified personnel to provide adequate problem and pathological gambling treatment, facility security, client safety and other special needs of clients.

(5) Ensure all persons providing counseling services are credentialed by the department of health.

(6) Assign the responsibility of TB infection control manager to a program individual in order to assess the program's annual tuberculosis risk according to the center for disease control guidelines.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0110, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0115 What must be included in a program administrative manual? Treatment programs not certified or licensed under chapter 388-805 or 388-865 WAC must have and adhere to an administrative manual, which contains policies and procedures that include:

(1) How services will be made sensitive to the needs of each client, including assurance that:

(a) Certified interpreters or other acceptable alternatives are available for persons with limited English-speaking proficiency and persons having a sensory impairment; and

(b) Assistance will be provided to persons with disabilities in case of an emergency.

(2) An organization chart specifying:

(a) The governing body;

(b) Each staff position by job title, including volunteers, students, and persons on contract; and

(c) The number of full or part-time persons for each position.

(3) A delegation of authority policy.

(4) A copy of current fee schedules.

(5) Implementing state and federal regulations on client confidentiality, including provision of a summary of 45 CFR Part 160 and 164 to each client.

(6) Reporting suspected child abuse and neglect.

(7) Reporting the death of a client to the department within one business day when a client dies on the premises.

(8) A client grievance policy and procedures.

(9) Reporting of critical incidents and actions taken to the department within two business days when an unexpected event occurs.

(10) An evacuation plan for use in the event of a disaster or emergency, addressing:

(a) Communication methods for clients, staff, and visitors including persons with a visual or hearing impairment or limitation;

(b) Evacuation of mobility-impaired persons;

(c) Evacuation of children if child care is offered;

(d) Different types of disasters or emergencies;

(e) Placement of posters showing routes of exit; and

(f) The need to mention evacuation routes at public meetings.

(11) A smoking policy consistent with the Washington Clean Indoor Air Act, chapter 70.160 RCW.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0115, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0120 What must be included in a treatment program personnel manual? Treatment programs not certified or licensed under chapter 388-805 or 388-865 WAC must have and adhere to a personnel manual, which contains policies and procedures that include:

(1) How the program conducts criminal background checks on its employees in order to comply with the rules specified in RCW 43.43.830 through 43.43.842.

(2) How the program provides staff orientation prior to assigning unsupervised duties, including orientation to:

(a) The administrative, personnel and clinical manuals;

(b) Staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities;

(c) Staff and client grievance procedures; and

(d) The facility evacuation plan.

(3) Provision for a drug free work place which includes:

(a) A philosophy of nontolerance of illegal drug-related activity;

(b) Program standards of prohibited conduct; and

(c) Actions to be taken in the event a staff member misuses alcohol or other drugs.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0120, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0125 What are treatment program personnel file requirements? In treatment programs not certified or licensed under chapter 388-805 or 388-865 WAC the administrator must:

(1) Ensure that there is a current personnel file for each employee, trainee, student, and volunteer, and for each contract staff person who provides or supervises client care.

(2) Designate a person to be responsible for management of personnel files.

(3) Ensure each person's file contains:

(a) Evidence a criminal background check was completed per WAC 388-816-0120(1);

(b) A copy of the results of an initial tuberculin skin test or evidence the person has completed a course of treatment approved by a physician or local health officer if the results are positive and subsequent annual tuberculosis screening and risk assessment based on the program annual TB risk assessment; and

(c) A record of an orientation to the program as described in WAC 388-816-0120(2).

(4) Ensure that each personnel file for clinical staff members providing client care contains:

(a) Verification of qualifications including, for each person engaged in the treatment of problem or pathological gambling, including counselors, physicians, nurses, and other certified, or licensed health care professionals, evidence they comply with the credentialing requirements of their respective professions;

(b) A copy of a current job description, signed and dated by the employee and supervisor which includes:

(i) Job title;

(ii) Minimum qualifications for the position; and

(iii) Summary of duties and responsibilities.

(c) A written performance evaluation for each year of employment:

(i) Conducted by the immediate supervisor of each staff member; and

(ii) Signed and dated by the employee and supervisor.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0125, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0130 What are the minimum qualifications for clinical staff members providing problem and pathological gambling treatment? (1) All clinical staff members and approved clinical supervisors providing problem and pathological gambling treatment must have a credential issued by the department of health in a counseling profession per chapter 18.19, 18.83, or 18.225 RCW.

(2) Each clinical staff member credentialed per chapter 18.19 RCW providing treatment services to a client must provide documentation of at least fifteen hundred hours of professionally supervised post-certification or post-registration experience providing mental health or chemical dependency treatment services.

(3) Each clinical staff member providing treatment services must have at least a bachelor's degree from an accredited college-level institution.

(a) The department will review requests for an exemption to this requirement on a case-by-case basis.

(b) In order to qualify for an exemption, the employee must possess year-for-year professional level experience equivalent to a bachelor's degree. The department determines this equivalency at the discretion of the department program manager responsible for monitoring problem gambling treatment programs.

(4) Each clinical staff member providing treatment services under supervision must:

(a) Complete a minimum of thirty hours of unduplicated gambling specific training including the sixteen-hour basic training, approved by a state, national, or international organization including but not limited to:

(i) Washington state gambling counselor certification committee;

(ii) National gambling counselor certification board;

(iii) International Gambling Counselor Certification Board; or

(iv) The department.

(b) Provide documentation of a minimum of one hundred hours of supervised experience working with problem and pathological gamblers and their significant others; and

(c) Receive a passing score on the national gambling counselor examination before providing unsupervised treatment services to program clients.

(5) Each clinical staff member credentialed per chapter 18.19 RCW providing unsupervised treatment services to program clients must:

(a) Be certified as a Washington state certified gambling counselor; or

(b) Be certified as a national certified gambling counselor.

(6) Approved clinical supervisors must:

(a) Hold a valid international gambling counselor certification board approved clinical consultant credential; or

(b) Hold a valid national certified gambling counselor II or Washington state certified gambling counselor II certification credential; and

(c) Complete six hours of training on gambling specific clinical supervision approved by the recognized organizations listed in WAC 388-816-0130 (4)(a)(i) through (iv).

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0130, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0135 What must be included in the treatment program clinical manual? Treatment programs not certified or licensed under chapter 388-805 or 388-865 WAC must have and adhere to a clinical manual, which contains policies and procedures that include:

(1) How the program meets WAC 388-816-0135 through 388-816-0180 requirements.

(2) Identification of resources and referral options so staff can make referrals required by law and as indicated by client needs.

(3) Client admission, continued service, and discharge criteria.

(4) How the program implements the following requirements:

(a) The administrator must not admit or retain a person unless the person's treatment needs can be met.

(b) Clinical staff members must assess and refer each client to the appropriate treatment service.

(5) Tuberculosis (TB) screening for prevention and control of TB in all outpatient programs, including:

(a) Obtaining a history of preventive or curative therapy;

(b) Screening and related procedures for coordinating with the local health department; and

(c) Implementing TB control as provided by the department of health TB control program.

(6) Limitation of group counseling sessions to twelve or fewer clients.

(7) Use of self-help groups.

(8) Client rules and responsibilities.

(9) How the program manages:

(a) Medical emergencies; and

(b) Suicidal, chemically dependent and mentally ill clients.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0135, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0140 What are clients' rights requirements in certified treatment programs? (1) Each certified treatment program must ensure a client:

(a) Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria.

(b) Is reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.

(c) Is treated in a manner sensitive to individual needs and which promotes dignity and self-respect.

(d) Is protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises.

(e) Has all clinical and personal information treated in accord with state and federal confidentiality regulations.

(f) Has the opportunity to review their own treatment records in the presence of the administrator or designee.

(g) Has the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the program or by referral.

(h) Is fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available.

(i) Is protected from abuse by staff at all times, or from other clients who are on program premises, including:

(i) Sexual abuse or harassment;

(ii) Sexual or financial exploitation;

(iii) Racism or racial harassment; and

(iv) Physical abuse or punishment.

(j) Is fully informed and receives a copy of counselor disclosure requirements established under RCW 18.19.060.

(k) Receives a copy of client grievance procedures upon request.

(l) Is, in the event of a program closure or treatment service cancellation:

(i) Given thirty days notice;

(ii) Assisted with relocation;

(iii) Given refunds to which the person is entitled; and

(iv) Advised how to access records to which the person is entitled.

(2) A disclosure authorization to a health care provider or health care facility as required by RCW 70.02.030 must:

(a) Be in writing, dated, and signed by the client;

(b) Identify the nature of the information to be disclosed;

(c) Identify the name and institutional affiliation of the person or class of persons to whom the information is to be disclosed;

(d) Identify the program or person who is to make the disclosure;

(e) Identify the client; and

(f) Contain an expiration date or an expiration event that relates to the client or the purpose of the use or disclosure.

(3) A treatment program must notify clients that outside persons or organizations which provide services to the program are required by written agreement to protect client confidentially.

(4) The administrator must ensure a copy of clients' rights is given at admission to each client receiving services.

(5) The administrator must post a copy of clients' rights in a conspicuous place in the facility accessible to clients and staff.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0140, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0145 What are the requirements for problem and pathological gambling assessments? Treatment programs must require all clinical staff members to obtain, review, evaluate and document a face-to-face diagnostic assessment of each client's involvement with problem and pathological gambling. The assessment must include, if not already documented in a chemical dependency or mental health assessment, the following information:

(1) Legal history describing any involvement with the criminal justice system.

(2) Medical and health history including all prescribed medications.

(3) Mental health history and current mental health status.

(4) Suicidal/homicidal assessment including past suicide attempts, methods, suicide plan, family history of suicide attempts, and suicide intent.

(5) Substance abuse history and screening describing current use, past use including amounts and duration and treatment history.

(6) Family history describing family composition and dynamics.

(7) If client is other than the problem or pathological gambler, a family assessment must be completed.

(8) Education status and history.

(9) Vocational or employment status and history describing skills or trades learned, jobs held, duration of employment, and reasons for leaving.

(10) Peers and friends, indicating interpersonal relationships and interaction with people and groups outside the home.

(11) A financial evaluation and information, including current financial status, gambling debts, any previous bankruptcy or repayment plans, and insurance coverage.

(12) Problem gambling screens.

(13) Documentation of the information collected, including:

(a) A diagnostic assessment statement including sufficient data to determine a client diagnosis supported by DSM IV TR criteria or subsequent editions.

(b) A written summary of the data gathered in subsections (1) through (12) of this section that supports the treatment recommendation.

(14) Evidence the client:

(a) Was notified of the assessment results; and

(b) Documentation of treatment options provided, and the client's choice; or

(c) If the client was not notified of the results and advised of referral options, the reason must be documented.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0145, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0150 What are the requirements for treatment, continuing care, transfer, and discharge plans? (1) Treatment programs must require clinical staff members be responsible for the overall treatment plan for each client, including:

(a) Client involvement in treatment planning;

(b) Documentation of progress toward client attainment of goals; and

(c) Completeness of client records.

(2) A clinical staff member must:

(a) Develop the individualized treatment plan based upon the assessment and update the treatment plan based upon achievement of goals, or when new problems are identified;

(b) Conduct individual or group counseling;

(c) Develop the continuing care plan; and

(d) Complete the discharge summary.

(3) A clinical staff member must follow up when a client misses an appointment to:

(a) Try to motivate the client to stay in treatment; and

(b) Report a noncompliant client to the committing authority as appropriate.

(4) When a client gives written consent, a clinical staff member must involve each client's family or other support persons:

(a) In the treatment program; and

(b) In self-help or support groups.

(5) A clinical staff member must meet with each client at the time of discharge from any treatment program to:

(a) Finalize a continuing care plan to assist in determining appropriate recommendation for care;

(b) Refer the client in making contact with necessary agencies or services; and

(c) Provide the client a copy of the plan.

(6) When transferring a client to another treatment program, the current program must forward copies of the following information to the receiving program when a release of confidential information is signed by the client:

(a) Client's demographic information;

(b) Diagnostic assessment statement and other assessment information, including:

(i) TB screen or test result;

(ii) The reason for the transfer; and

(iii) Court mandated status or program recommended follow-up treatment.

(c) Discharge summary; and

(d) The plan for continuing care or treatment.

(7) A clinical staff member must complete a discharge summary, within seven days of each client's discharge from the program, which includes:

(a) The date of discharge; and

(b) A summary of the client's progress toward each treatment goal.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0150, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0155 What are the requirements for a client record system? Treatment programs not certified or licensed by either chapter 388-805 or 388-865 WAC must have a comprehensive client record system maintained in accord with recognized principles of health record management. The program must ensure:

(1) A designated individual is responsible for the record system;

(2) A secure storage system which:

(a) Promotes confidentiality of and limits access to both active and inactive records; and

(b) Protects active and inactive files from damage during storage.

(3) Client record policies and procedures on:

(a) Who has access to records;

(b) Content of active and inactive client records;

(c) A systematic method of identifying and filing individual client records so each can be readily retrieved;

(d) Assurance that each client record is complete and authenticated by the person providing the observation, evaluation, or service;

(e) Retention of client records for a minimum of six years after the discharge or transfer of the client; and

(f) Destruction of client records.

(4) In addition to subsections (1) through (3) of this section, that programs maintaining electronic client records:

(a) Make records available in paper form upon request:

(i) For review by the department; and

(ii) To clients requesting record review as authorized by WAC 388-816-0140(6).

(b) Provide secure, limited access through means that prevent modification or deletion after initial preparation;

(c) Provide for back up of records in the event of equipment, media or human error;

(d) Provide for protection from unauthorized access, including network and internet access.

(5) In case of a program closure, the closing treatment program must arrange for the continued management of all client records. The closing program must notify the department in writing of the mailing and street address where records will be stored and specify the person managing the records. The closing program:

(a) May continue to manage the records and give assurance they will respond to authorized requests for copies of client records within a reasonable period of time;

(b) May transfer records of clients who have given written consent to another certified program;

(c) May enter into a business associate agreement with a certified program to store and manage records, when the outgoing program will no longer be a problem and pathological gambling treatment program; or

(d) Must, in the event none of the arrangements listed in (a) through (c) of this subsection can be made, arrange for transfer of client records to the department.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0155, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0160 What are the requirements for client record content? Treatment programs must ensure client record content includes:

(1) Demographic information;

(2) A problem and pathological gambling assessment;

(3) Documentation the client was informed of the diagnostic assessment and options for referral or the reason not informed;

(4) Documentation the client was informed of federal confidentiality requirements and received a copy of the client notice required under 45 CFR, Part 160 through 164;

(5) Documentation the client was informed of treatment service rules, translated when needed, signed and dated by the client before beginning treatment;

(6) Voluntary consent to treatment signed and dated by the client;

(7) Documentation the client received counselor disclosure information, acknowledged by the program and client by signature and date;

(8) Initial and updated individual treatment plans, including results of the initial assessment and periodic reviews, addressing:

(a) Client biopsychosocial problems;

(b) Treatment goals;

(c) Estimated dates or conditions for completion of each treatment goal;

(d) Approaches to resolve the problems;

(e) Identification of persons responsible for implementing the approaches;

(f) Medical orders, if appropriate.

(9) Documentation of referrals made for specialized care or services;

(10) Progress notes as events occur, which include:

(a) Date, duration, and content of counseling and other treatment sessions; and

(b) Ongoing assessments of each client's participation in and response to treatment and other activities.

(11) Treatment plan reviews as required by WAC 388-816-0175 (1)(d)(i) and (ii);

(12) Properly completed authorizations for release of information;

(13) Copies of all correspondence related to the client, including any court orders and reports of noncompliance; and

(14) A continuing care plan and discharge summary.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0160, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0165 What are the requirements for reporting client noncompliance? The following standards define client noncompliance behaviors and sets minimum time lines for reporting these behaviors to the appropriate court or court designated authority.

(1) Reporting client noncompliance is contingent upon obtaining a properly completed authorization to release confidential information form.

(2) For emergent noncompliance: The following noncompliance is considered emergent noncompliance and must be reported to the appropriate court within three working days from obtaining the information. The client:

(a) Fails to follow requirements in court order;

(b) Reports a subsequent gambling related arrest; and

(c) Leaves a program against program advice or is discharged for rule violation.

(3) For nonemergent noncompliance: The following noncompliance is considered nonemergent noncompliance and must be reported to the appropriate court as required by subsection (4) and (5) of this section and needs to include the program's recommendations for engaging the client. The client:

(a) Has unexcused absences or failure to report. Programs must report all client unexcused absences.

(b) Fails to provide program with documentation of attendance at self-help or support groups if required by the treatment plan.

(c) Fails to make acceptable progress in any part of the treatment plan.

(4) If a court accepts monthly progress reports, nonemergent noncompliance may be reported in monthly progress reports, which must be mailed to the court within ten working days from the end of each reporting period.

(5) If a court does not wish to receive monthly reports and only requests notification of noncompliance or other significant changes in client status, the reports should be transmitted as soon as possible, but not longer than ten working days from the date of the noncompliance.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0165, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0170 What are the requirements for outcomes evaluation? Each treatment program:

(1) Must develop and implement policies and procedures for outcomes evaluation; and

(2) Is responsible to monitor and evaluate program effectiveness and client satisfaction for the purpose of program improvement.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0170, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0175 What are the requirements for outpatient services? All treatment programs certified by this chapter must meet the following requirements:

(1) A clinical staff member, must:

(a) Complete an assessment prior to admission unless participation in this outpatient treatment service is part of the same program's continuum of care.

(b) Complete an initial individualized treatment plan prior to the client's participation in treatment.

(c) Conduct group, individual or conjoint problem or pathological gambling counseling sessions for each client, each month, according to an individual treatment plan.

(d) Conduct and document a treatment plan review for each client:

(i) Once a month for the first three months; and

(ii) Quarterly thereafter or sooner if required by other laws.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0175, filed 12/22/10, effective 1/22/11.]

WAC 388-816-0180 What are the requirements for providing off-site problem and pathological gambling treatment services? If a certified program wishes to offer treatment services, for which the program is certified, at a site where clients are located primarily for purposes other than problem and pathological gambling, the administrator must:

(1) Ensure off-site treatment services will be provided:

(a) In a private, confidential setting that is discrete from other services provided within the off-site location; and

(b) By a clinical staff member.

(2) Include a description in the program policy and procedures manuals of how confidentiality will be maintained at each off-site location, including how confidential information and client records will be transported between the certified facility and the off-site location.

[Statutory Authority: 2010 c 171 § 1 (1) and (4), and RCW 43.20A.890, 74.08.090. 11-02-003, § 388-816-0180, filed 12/22/10, effective 1/22/11.]

Chapter 388-825 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES RULES

(Formerly chapter 275-27 WAC)

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-825-160 When will a decision on my appeal be made? [Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-160, filed 8/19/05, effective 9/19/05.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-200 What is the purpose of the family support opportunity program? [99-19-104, recodified as § 388-825-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-180, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-205 Who is eligible to participate in the family support opportunity program? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-205, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-205, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-185, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-210 What basic services can my family receive from the family support opportunity program? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-210, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-

014, § 388-825-210, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-190, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-220 What is the purpose of community guide services? [99-19-104, recodified as § 388-825-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.-030. 99-04-071, § 275-27-191, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-222 Who can become a community guide? [99-19-104, recodified as § 388-825-222, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-192, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.-040.

388-825-224 Does my family have a choice in selecting its community guide? [99-19-104, recodified as § 388-825-224, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-193, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-226 Can the family support opportunity program help my family obtain financial assistance for community guide services? [Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-226, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-226, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-226, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-226, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-194, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-228 How can short-term intervention services through the family support opportunity program help my family? [Statutory Authority: RCW 71A.12.030, 2005 c 518 § 205 (1)(a). 06-11-082, § 388-825-228, filed 5/16/06, effective 6/16/06. Statutory Authority: RCW 71A.12.-030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-228, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-228, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-228, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-228, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-228, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-195, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-230 Specifically how can short-term intervention funds be used? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-230, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-196, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-232 How can serious need funds help my family? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.-120], and chapter 71A.12 RCW. 04-22-068, § 388-825-232, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-232, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-197, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.-040.

388-825-234 How can my family qualify for serious need funds? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-234, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-234, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-234, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-198, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-236 How does my family request serious need funds? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-236, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-236, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-199, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.-040.

388-825-238 What amount of serious need funding is available to my family? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-238, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-238, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-238, filed 11/21/00, effective 12/22/00. 99-19-104, recodified as § 388-825-238, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.-030. 99-04-071, § 275-27-200, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-240 Who determines what family support services my family can receive? [99-19-104, recodified as § 388-825-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-202, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-242 What department restrictions apply to family support payments? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-242, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-242, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-204, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-244 What are regional family support advisory councils? [99-19-104, recodified as § 388-825-244, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.-030. 99-04-071, § 275-27-211, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-246 What are community service grants? [99-19-104, recodified as § 388-825-246, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-212, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-248 Who is covered under these rules? [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-248, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-248, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-248, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.-030. 99-04-071, § 275-27-213, filed 2/1/99, effective 3/4/99.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-250 Continuity of family support services. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.-030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-250, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-250, filed 9/20/99, effective 9/20/99. Statutory Author-

ity: RCW 71A.12.040. 92-13-024 (Order 3394), § 275-27-219, filed 6/9/92, effective 7/10/92.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-252 Family support services. [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-252, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-252, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-252, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-252, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-220, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.-040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-220, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-220, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-220, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-220, filed 8/29/86.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-253 Family support service restrictions. [Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-253, filed 10/29/04, effective 11/29/04.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-254 Service need level rates. [Statutory Authority: RCW 71A.12.030, 2005 c 518 § 205 (1)(a). 06-11-082, § 388-825-254, filed 5/16/06, effective 6/16/06. Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.-120], and chapter 71A.12 RCW. 04-22-068, § 388-825-254, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-254, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-254, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-254, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-254, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-254, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-222, filed 6/13/97, effective 7/14/97.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.-040.

388-825-256 Service need levels. [99-19-104, recodified as § 388-825-256, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-223, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.-040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-223, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-223, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-223, filed 2/5/88.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-500 What is the family support pilot? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-500, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-505 What is the statutory authority for the family support pilot? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-505, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-510 Who is eligible to participate in the family support pilot? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-510, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.-040.

388-825-512 What is the definition of family? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-512, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-513 What is the definition of an "award"? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-513, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-514 If I participate in the FSP, will I be eligible for services through the DDD home and community based services (HCBS) waiver? [Statutory Authority: RCW 71A.12.-030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-514, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-516 If I receive other DDD funded services do I qualify for the FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-516, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-520 If I qualify for and receive an FSP award, will my name remain on the family support waitlist? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-520, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-524 How do I apply for the FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-524, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-528 What will DDD do with the FSP questionnaire that you return? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-528, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and 71A.12.040.

388-825-532 How does DDD determine the federal poverty level (FPL) for my household? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-532, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-534 What are the annual federal poverty levels? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-534, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-536 What is "gross annual household income"? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-536, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-538 What is the definition of household? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-538, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-540 Who must declare their income? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-540, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-544 If I meet eligibility for FSP, will I receive paid services? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040,

§ 388-825-544, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-548 What is the amount of the FSP awards? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-548, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-552 What if there are two or more family members who qualify for FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-552, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-554 How will DDD determine who will receive awards for FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-554, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-558 What FSP services can my family and I receive? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-558, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-560 What department restrictions apply to FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, 2005 c 518 § 205 (1)(e), Title 71A RCW. 06-19-036, § 388-825-560, filed 9/13/06, effective 10/14/06; 06-06-040, § 388-825-560, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-562 What is an FSP plan? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-562, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-564 Does my family have a choice of FSP services? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-564, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-572 What if I have needs that exceed my FSP award limit? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-572, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-575 What are one-time awards? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-575, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-576 How do I apply for a one-time award? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-576, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-578 What amount of one-time funding is available for my family? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-578, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-581 How long do I remain eligible for the FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-581, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-584 Can I be terminated from FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-584, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-586 When are changes in my circumstances considered effective? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-586, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-588 How will the department notify me of their decisions? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-588, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-591 What are my appeal rights under the FSP? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-591, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

388-825-595 How do I appeal a department action? [Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-595, filed 2/23/06, effective 3/26/06.] Repealed by 10-02-101, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.030 and 71A.12.040.

WAC 388-825-020 Definitions. "Authorization" means DDD approval of funding for a service as identified in the individual support plan or evidence of payment for a service.

"Client or person" means a person who has a developmental disability as defined in RCW 71A.10.020(3) who also has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"Department" means the department of social and health services of the state of Washington.

"Director" means the director of the division of developmental disabilities.

"Division or DDD" means the division of developmental disabilities within the aging and disability services administration of the department of social and health services.

"Family" means relatives who live in the same home with the eligible client. Relatives include spouse or registered domestic partner; natural, adoptive or step parent; grandparent; child; stepchild; sibling; stepsibling; uncle; aunt; first cousin; niece; or nephew.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide diagnosis, treatment and rehabilitation services to the mentally retarded or persons with related conditions.

"ICF/MR eligible" for admission to an ICF/MR means a person is determined by DDD as needing active treatment as defined in CFR 483.440. Active treatment requires:

(1) Twenty-four hour supervision; and

(2) Continuous training and physical assistance in order to function on a daily basis due to deficits in the following areas: Toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication.

"Individual support plan (ISP)" is a document that authorizes and identifies the DDD paid services to meet a client's assessed needs.

"Medicaid personal care" is the provision of medically necessary personal care tasks as defined in chapter 388-106 WAC.

"Residential habilitation center" or **"RHC"** means a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities.

"Residential programs" means provision of support for persons in community living situations. Residential programs include DDD certified community residential services and support, both facility-based such as licensed group homes, and nonfacility based, such as supported living and state-operated living alternatives (SOLA). Other residential programs include alternative living (as described in chapter 388-829A WAC, companion homes (as described in chapter 388-829C WAC), adult family homes, adult residential care services, children's foster homes, group care and staffed residential homes.

"Respite care" means short-term intermittent relief for persons normally providing care for the individuals.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"State supplementary payment (SSP)" is the state paid cash assistance program for certain DDD eligible SSI clients.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-020, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-020, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-020, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-020, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, amended and recodified as § 388-825-020, filed 11/9/99, effective 12/10/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-020, filed 2/1/99, effective 3/4/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-020, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-27-020, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-020, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-020, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-020, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-020, filed 3/16/78; Order 1143, § 275-27-020, filed 8/11/76.]

WAC 388-825-068 What medicaid state plan services can DDD authorize? DDD may authorize the following medicaid state plan services:

(1) Medicaid personal care, per chapter 388-106 WAC;

(2) Private duty nursing for adults age eighteen and older; per chapter 388-106 WAC;

(3) Private duty nursing for children under the age of eighteen, per WAC 388-551-3000;

(4) Adult day health for adults, per chapter 388-106 WAC; and

(5) ICF/MR services, per chapters 388-835 and 388-837 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, 71A.14.030, 2009 c 564, section 205 (1)(j), and section 1915(i) of the Social Security Act. 10-04-002, § 388-825-068, filed 1/21/10, effective 2/21/10. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-068, filed 5/19/08, effective 6/19/08.]

WAC 388-825-081 Can I receive state-only funded services that are not available in a DDD HCBS waiver? You may be authorized to receive state-only funded services that are available in other DSHS rules as defined below:

(1) Adult day care (WAC 388-106-0800);

(2) Attendant care (WAC 388-825-082);

(3) Childcare for foster children (chapter 388-826 WAC);

(4) Chore services (chapter 388-106 WAC);

(5) Individual and family assistance by the county (WAC 388-825-082);

(6) Information and education by the county (WAC 388-825-082);

(7) Medical and dental services (WAC 388-825-082);

(8) Psychological counseling (WAC 388-825-082);

(9) Reimbursement through the individual and family support program to families for the purchase of approved items or service (chapter 388-832 WAC);

(10) State supplementary payments (chapter 388-827 WAC); and

(11) Transportation reimbursement for an escort (WAC 388-825-082).

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-081, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-081, filed 5/19/08, effective 6/19/08.]

WAC 388-825-083 Is there a comprehensive list of waiver and state-only DDD services? For medicaid state plan services authorized by DDD, see WAC 388-825-068. The following is a list of waiver and state-only services that DDD can authorize and those services that can be either a waiver or a state-only service:

(1) **Waiver personal care services that are not available with state-only funds include:**

(a) In-home services;

(b) Adult family home; and

(c) Adult residential care.

(2) **Waiver services that can be funded as state-only services:**

(a) Behavior management and consultation;

(b) Community transition;

(c) Environmental accessibility adaptations;

(d) Medical equipment and supplies;

(e) Occupational therapy;

(f) Physical therapy;

(g) Respite care;

(h) Sexual deviancy evaluation;

(i) Skilled nursing;

(j) Specialized medical equipment or supplies;

(k) Specialized psychiatric services;

(l) Speech, hearing and language therapy;

(m) Staff/family consultation and training;

(n) Transportation/mileage;

(o) Residential habilitation services (RHS), including:

(i) Alternative living;

(ii) Companion homes;

(iii) Supported living;

(iv) Group home;

(v) Child foster care;

(vi) Child group care;

(vii) Staffed residential; and

(viii) State operated living alternative (SOLA);

(p) Employment/day programs, including:

(i) Community access;

(ii) Community guide;

(iii) Person-to-person;

(iv) Prevocational services; and

(v) Supported employment;

(q) ITEIP/County programs, including child development services;

(r) Mental health stabilization services, including:

(i) Behavior management and consultation;

(ii) Mental health crisis; and

(iii) Skilled nursing; and

(s) Specialized psychiatric services.

(3) **State-only services that are not available as a waiver service:**

(a) Adult day care;

(b) Architectural and vehicle modification;

(c) Attendant care;

(d) Child care for foster children;

(e) Chore services;

(f) Community services grant;

(g) Individual and family assistance;

(h) Information/education;

(i) Medical and dental services;

(j) Medical insurance copays and costs exceeding other coverage;

(k) Parent and sibling education;

(l) Parent training and counseling;

(m) Psychological counseling;

(n) Recreational opportunities;

(o) State supplementary payments;

(p) Specialized clothing;

(q) Specialized nutrition;

(r) Training of the client;

(s) Transportation - cost of escort service or travel time; and

(t) Reimbursement to families for the purchase of approved items or services.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-083, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-083, filed 5/19/08, effective 6/19/08.]

WAC 388-825-084 What are the limitations of state-only funded services or programs? In addition to any limitations for state-only funded services or programs that are contained in the program specific rules, the following limitations apply to state-only funded services and programs.

(1) All state-only funded services are limited by available funding.

(2) The following programs are closed to new admissions:

(a) Adult day care; and

(b) Attendant care.

(3) Chore services are limited to persons who were receiving the service in 1998 and who have continued to receive this service monthly.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-084, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-084, filed 5/19/08, effective 6/19/08.]

WAC 388-825-089 What is a residential habilitation center (RHC)? A residential habilitation center or RHC is a state-operated facility certified to provide ICF/MR services (see chapter 388-837 WAC) and/or nursing facility services (chapter 388-97 WAC) for persons who are eligible clients of DDD. RHCs include:

(1) Rainier School in Buckley, Washington;

(2) Francis Hadden Morgan Center in Bremerton, Washington;

(3) Fircrest School in Shoreline, Washington;

(4) Yakima Valley School in Selah, Washington; and

(5) Lakeland Village in Medical Lake, Washington.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-089, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-089, filed 5/19/08, effective 6/19/08.]

WAC 388-825-100 How will I be notified of decisions made by DDD? (1) Whenever possible, DDD will notify all parties affected by the decision by phone or in person.

(2) If you are under the age of eighteen, written notifications will be mailed to:

(a) Your parent; or

(b) Your guardian or other legal representative.

(3) If you are age eighteen or older, written notifications will be mailed to you and:

(a) Your guardian or other legal representative; or

(b) A person identified by you to receive these notices in addition to yourself if you do not have a guardian or legal representative. Unless the person identified by you is a relative of yours, he or she cannot be an employee of DDD, a contractor with DDD or an employee of a contractor with DDD.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-100, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71.10.060, 71A.12.030, and Title 71A RCW. 08-16-122, § 388-825-100, filed 8/5/08, effective 9/5/08. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-100, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-100, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-100, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-400, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-400, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-400, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-400, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-400, filed 3/16/78; Order 1143, § 275-27-400, filed 8/11/76.]

WAC 388-825-103 When will I receive written notice of decisions made by DDD? You will receive written notice from DDD of the following decisions:

(1) The denial or termination of eligibility for services under WAC 388-825-057;

(2) Denial or termination of the provider of your choice for any reason listed in WAC 388-825-375 through 388-825-390;

(3) The authorization, denial, reduction, or termination of services or the payment of SSP set forth in chapter 388-827 WAC that are authorized by DDD;

(4) The admission or readmission to, or discharge from a residential habilitation center set forth in WAC 388-825-155; or

(5) Disenrollment from a DDD home and community based services waiver under WAC 388-845-0060, including a disenrollment from a waiver and enrollment in a different waiver.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-103, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030 and Title 71A RCW. 08-04-072, § 388-825-103, filed 2/4/08, effective 3/6/08. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-825-103, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.-040. 04-15-093, § 388-825-103, filed 7/16/04, effective 8/16/04.]

WAC 388-825-120 When can I appeal department decisions through an administrative hearing process? (1) Administrative hearings are governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 71A.10.050, the rules in this chapter and by chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC or WAC 388-440-0001(3), the provision in this chapter shall prevail.

(2) A client, former client, or applicant acting on the applicant's own behalf or through an authorized representative has the right to an administrative hearing.

(3) You have the right to an administrative hearing to dispute the following department actions:

(a) Authorization, denial, reduction, or termination of services;

(b) Reduction or termination of a service that was initially approved through an exception to rule;

(c) Authorization, denial, or termination of eligibility;

(d) Authorization, denial, reduction, or termination of payment of SSP authorized by DDD set forth in chapter 388-827 WAC;

(e) Admission or readmission to, or discharge from, a residential habilitation center set forth in WAC 388-825-155;

(f) Refusal to abide by your request not to send notices to any other person;

(g) Refusal to comply with your request to consult only with you;

(h) A decision to move you to a different type of residential service;

(i) Denial or termination of the provider of your choice or the denial of payment for any reason listed in WAC 388-825-375 through 388-825-390;

(j) An unreasonable delay to act on an application for eligibility or service;

(k) A claim the client, former client, or applicant owes an overpayment debt.

(4) If you are not enrolled in a waiver and your request to be enrolled in a waiver is denied, your appeal rights are limited to the decision that you are not eligible to have your request documented in a statewide data base because you do not need ICF/MR level of care per WAC 388-845-0070, 388-828-8040 or 388-828-8060.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-120, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030. 06-19-037, § 388-825-120, filed 9/13/06, effective 10/14/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-120, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.10.-020 and 2002 c 371. 04-02-014, § 388-825-120, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-120, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-500, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.-030]. 90-04-074 (Order 2997), § 275-27-500, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-500, filed 8/29/86. Statutory Authority: RCW 72.33.161. 84-15-038 (Order 2122), § 275-27-500, filed 7/13/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-500, filed 3/16/78; Order 1143, § 275-27-500, filed 8/11/76.]

WAC 388-825-140 Who else can help me appeal a department decision? Department staff may assist you in requesting an administrative hearing. You may authorize anyone except an employee of the department to represent you at an administrative hearing.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-140, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030, 71A.12.120. 05-17-135, § 388-825-140, filed 8/19/05, effective 9/19/05.]

WAC 388-825-165 Where can I find additional information about the appeal process? You may find additional information governing the appeal process in chapter 388-02 WAC.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-165, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030, 71A.12.120. 05-17-135, § 388-825-165, filed 8/19/05, effective 9/19/05.]

WAC 388-825-325 What are required skills and abilities for individuals and agencies contracted to provide respite care, personal care services through the medicaid personal care program or the DDD HCBS Basic, Basic Plus, CIIBS, or Core waivers, or attendant care services? (1) As a provider of respite care, personal care services through the medicaid personal care program or the DDD HCBS Basic, Basic Plus, CIIBS, or Core waivers, or attendant care services, you must be able to:

(a) Adequately maintain records of services performed and payments received;

(b) Read and understand the person's service plan. Translation services may be used if needed;

(c) Be kind and caring to the DSHS client for whom services are authorized;

(d) Identify problem situations and take the necessary action;

(e) Respond to emergencies without direct supervision;

(f) Understand the way your employer wants you to do things and carry out instructions;

(g) Work independently;

(h) Be dependable and responsible;

(i) Know when and how to contact the client's representative and the client's case resource manager;

(j) Participate in any quality assurance reviews required by DSHS;

(2) If you are working with an adult client of DSHS as a provider of attendant care, you must also:

(a) Be knowledgeable about the person's preferences regarding the care provided;

(b) Know the resources in the community the person prefers to use and enable the person to use them;

(c) Know who the person's friends are and enable the person to see those friends; and

(d) Enable the person to keep in touch with his/her family as preferred by the person.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-325, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-325, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-325, filed 8/19/05, effective 9/19/05.]

WAC 388-825-330 What is required for agencies wanting to provide care in the home of a person with developmental disabilities? (1) Agencies providing personal care or respite services must be licensed as a home care agency or a home health agency through the department of health per chapter 246-335 WAC.

(2) If a residential agency certified per chapter 388-101 WAC wishes to provide medicaid personal care or respite care in the client's home, the agency must have home care agency certification or a home health license.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-330, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030, 71A.12.120. 05-17-135, § 388-825-330, filed 8/19/05, effective 9/19/05.]

WAC 388-825-365 Are providers expected to report abuse, neglect, exploitation or financial exploitation? Providers must report any abuse or suspected abuse immediately to child protective services, adult protective services or local law enforcement and make a follow-up call to the person's case manager.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-365, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-030, 71A.12.120. 05-17-135, § 388-825-365, filed 8/19/05, effective 9/19/05.]

WAC 388-825-375 When will the department deny payment for services of an individual or home care agency providing respite care, attendant care, or personal care services? (1) The department will deny payment for the services of an individual or home care agency providing respite care, attendant care, or personal care who:

(a) Is the client's spouse, per 42 C.F.R. 441.360(g), except in the case of an individual provider for a chore services client. Note: For chore spousal providers, the department pays a rate not to exceed the amount of a one-person standard for a continuing general assistance grant, per WAC 388-478-0030;

(b) Is providing services under this chapter to their natural/step/adoptive minor client aged seventeen or younger;

(c) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830;

(d) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW;

(e) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations;

(f) Does not successfully complete the training requirements within the time limits required in WAC 388-71-05665 through 388-71-05909; or

(g) Is terminated by the client (in the case of an individual provider) or by the home care agency (in the case of an agency provider).

(2) In addition, the department may deny payment to or terminate the contract of an individual provider as provided under WAC 388-825-380, 388-825-385 and 388-825-390.

[Statutory Authority: RCW 71A.12.030 and 71A.12.040. 10-02-101, § 388-825-375, filed 1/6/10, effective 2/6/10. Statutory Authority: RCW 71A.12.-30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-375, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-375, filed 8/19/05, effective 9/19/05.]

Chapter 388-828 WAC

THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD) ASSESSMENT

WAC

388-828-1620	How does DDD determine which panels are mandatory in your DDD assessment?
388-828-8500	What is the children's intensive in-home behavioral support (CIIBS) program algorithm?
388-828-8505	When does the DDD assessment run the CIIBS algorithm to determine your eligibility for the CIIBS waiver?
388-828-8510	What elements does the CIIBS algorithm use to calculate your out-of-home placement risk score?
388-828-8515	How does DDD determine your CIIBS out-of-home placement risk score?
388-828-8520	How does DDD determine if I am eligible for the CIIBS waiver?

WAC 388-828-1620 How does DDD determine which panels are mandatory in your DDD assessment? DDD determines which panels are mandatory in your DDD assessment by assigning you to a client group using the following table:

If you are approved by DDD to receive:	Your client group is:
(1) DDD HCBS waiver services per chapter 388-845 WAC; or (2) State-only residential services per chapter 388-825 WAC; or (3) ICF/MR services per 42 CFR 440 and 42 CFR 483.	Waiver and State-Only Residential
(4) Medicaid personal care (MPC) per chapter 388-106 WAC; or (5) DDD HCBS Basic, Basic Plus, CIIBS or Core waiver services per chapter 388-845 WAC and personal care services per chapter 388-106 WAC; or (6) Medically intensive health care program services per chapter 388-551 WAC; or (7) Adult day health services per chapter 388-106 WAC; or (8) Private duty nursing services per chapter 388-106 WAC; or (9) Community options program entry system (COPES) services per chapter 388-106 WAC; or	Other Medicaid Paid Services

If you are approved by DDD to receive:	Your client group is:
(10) Medically needy residential waiver services per chapter 388-106 WAC; or (11) Medicaid nursing facility care services per chapter 388-106 WAC.	
(12) County employment services per chapter 388-850 WAC. (13) Other DDD paid services per chapter 388-825 WAC, such as: (a) Family support services; or (b) Professional services. (14) Nonwaiver voluntary placement program services per chapter 388-826 WAC; (15) SSP only per chapter 388-827 WAC;	State-Only Paid Services
(16) You are not approved to receive any DDD paid services.	No Paid Services

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 10-07-019, § 388-828-1620, filed 3/8/10, effective 4/8/10. Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1620, filed 4/23/07, effective 6/1/07.]

WAC 388-828-8500 What is the children's intensive in-home behavioral support (CIIBS) program algorithm? The children's intensive in-home behavioral support (CIIBS) program algorithm is a formula in the DDD assessment that calculates your out-of-home placement risk score to determine your eligibility for the CIIBS waiver per chapter 388-845 WAC.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 10-07-019, § 388-828-8500, filed 3/8/10, effective 4/8/10.]

WAC 388-828-8505 When does the DDD assessment run the CIIBS algorithm to determine your eligibility for the CIIBS waiver? The DDD assessment runs the CIIBS algorithm to determine your eligibility for the CIIBS waiver when your support assessment is moved to current and:

(1) You are the assessed age of eight or older and under age eighteen;

(2) Your behavior acuity level is high per WAC 388-828-5640;

(3) Your caregiver's risk score is medium, high or immediate per WAC 388-828-5300;

(4) Your ICF/MR score is eligible per WAC 388-828-4400; and

(5) You are not enrolled in the CIIBS waiver.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 10-07-019, § 388-828-8505, filed 3/8/10, effective 4/8/10.]

WAC 388-828-8510 What elements does the CIIBS algorithm use to calculate your out-of-home placement risk score? The CIIBS algorithm uses the following elements to determine your out-of-home placement risk score:

(1) The DDD protective supervision acuity scale (WAC 388-828-5000 to 388-828-5100);

(2) The DDD caregiver status acuity scale (WAC 388-828-5120 to 388-828-5360);

(3) The DDD behavioral acuity scale (WAC 388-828-5500 to 388-828-5640);

(4) The DDD activities of daily living (ADL) acuity scale (WAC 388-828-5380 to 388-828-5480);

(5) The DDD mobility acuity scale (WAC 388-828-5380 to 388-828-5480); and

(6) Eligible condition of "autism" as indicated in the DDD determination (WAC 388-823-0500).

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 10-07-019, § 388-828-8510, filed 3/8/10, effective 4/8/10.]

WAC 388-828-8515 How does DDD determine your CIIBS out-of-home placement risk score? Your CIIBS out-of-home placement risk score is calculated using the following table:

Section and WAC reference	If you meet the following criteria:	Then adjust your score by:	Score if you meet criteria
	Clients meeting eligibility criteria in WAC 388-828-8505		**Beginning Score = 0**
DDD Determination WAC 388-823-0500	Eligible condition of autism in the DDD determination.	Adding 40 points	=
ADL Acuity Level WAC 388-828-5480	Your ADL support needs level = high, medium or low	Subtracting 54 points	=
Behavior Acuity Scale WAC 388-828-5500 through 388-828-5640	Your most prominent behavior = assault/injury and Severity of your most prominent behavior = "potentially dangerous" or "life threatening"	Adding 14 points	=
Protective Supervision Acuity Scale WAC 388-828-5060	Your answer to the following question: "What level of monitoring does the client typically require during awake hours?" = "Line of sight/earshot"	Adding 13 points	=
DDD Caregiver Status Acuity WAC 388-828-5300	Your caregiver risk level = high or immediate	Adding 136 points	=

Section and WAC reference	If you meet the following criteria:	Then adjust your score by:	Score if you meet criteria
Backup Caregiver Status WAC 388-828-5320	Your answer to the following question: "Under what conditions are other caregiver(s) available?" = "No other caregiver available"	Adding 33 points	=
Mobility Acuity Scale WAC 388-828-5900	Your mobility acuity level = high, medium or low	Subtracting 15 points	=
		Sum of all of scores above is your CIIBS out-of-home placement risk score	=

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 10-07-019, § 388-828-8515, filed 3/8/10, effective 4/8/10.]

WAC 388-828-8520 How does DDD determine if I am eligible for the CIIBS waiver? DDD uses the following table to determine if you are eligible for the CIIBS waiver based on your CIIBS out-of-home placement risk score per WAC 388-828-8510:

If your CIIBS out-of-home placement risk score is:	Then your CIIBS eligibility is:
96 or greater	Yes - Severe
17 through 95	Yes - High
Less than 17	No - (not eligible)

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 10-07-019, § 388-828-8520, filed 3/8/10, effective 4/8/10.]

Chapter 388-831 WAC
COMMUNITY PROTECTION PROGRAM

WAC

388-831-0010 Definitions.
388-831-0030 Who are individuals with community protection issues?
388-831-0240 Can I be terminated from the community protection program?

WAC 388-831-0010 Definitions. The definitions in this section apply throughout the chapter unless the context clearly requires otherwise.

"Certified community protection program residential services" means access to twenty-four hour supervision, instruction, and support services as identified in the person's individual support plan.

"Community protection program" see WAC 388-831-0020.

"Constitutes a risk to others" means a determination of a person's risk and/or dangerousness based upon a thorough assessment by a qualified professional. Actuarial risk assessment instruments should be used to supplement clinical judgment whenever appropriate.

"Department" means the department of social and health services.

"Developmental disability" means that condition defined in WAC 388-823-0040 and RCW 71A.10.020(3).

"Disclosure" means providing copies of professional assessments, incident reports, legal documents, and other information pertaining to community protection issues to ensure the provider has all relevant information. Polygraph and plethysmograph reports are excluded from disclosure.

"Division" means the division of developmental disabilities (DDD).

"Managed successfully" means that a person supported by a community protection program does not engage in the behavior identified in WAC 388-831-0030 and RCW 71A.12.210.

"Opportunistic behavior" means an act committed on impulse, which is not premeditated. In determining whether an act is opportunistic, the original motive or intent of the offense or crime will be considered.

"Predatory" means acts directed toward strangers, individuals with whom a relationship has been established or promoted for the primary purpose of victimization, or casual acquaintances with whom no substantial personal relationship exists. Predatory behavior may be characterized by planning and/or rehearsing the act, stalking, and/or grooming the victim.

"Program participant" means a person who has agreed to and is receiving services and supports in the community protection program.

"Qualified professional" means a licensed psychologist, psychiatrist, or a certified or affiliate sex offender treatment provider with at least three years prior experience working with individuals with developmental disabilities, and:

• If the person being assessed has demonstrated sexually aggressive or sexually violent behavior, that person must be assessed by a certified sex offender treatment provider, or affiliate sex offender treatment provider working under the supervision of a certified sex offender treatment provider; or

• If the person being assessed has demonstrated violent, dangerous, or aggressive behavior, that person must be assessed by a licensed psychologist or psychiatrist who has received specialized training in the treatment of or has at least three years prior experience treating violent or aggressive behavior.

"Restrictive procedures" or "restrictions" means procedures that restrict a client's freedom of movement, restrict access to client property, prevent a client from doing something the client wants to do, require a client to do something the client does not want to do, or remove something the client owns or has earned.

"Risk assessment" means the written opinion of a qualified professional stating, at a minimum:

• Whether a person meets the criteria in WAC 388-831-0030 and RCW 71A.12.210; and

• What restrictions are necessary to keep people safe.

"Service provider" means a person or agency contracted with the department or a sub-contractor who delivers

services and supports to a community protection program participant.

"Specialized environment" means a place where the program participant has agreed to supervision in a safe, structured manner specifying rules, requirements, restrictions, and expectations for personal responsibility in order to maximize community safety.

"Treatment team" means the program participant and the group of people responsible for the development, implementation, and monitoring of the person's individual supports and services. This group may include, but is not limited to, the case resource manager, therapist, residential provider, employment/day program provider, and the person's legal representative and/or family, provided the person agrees to the family member's involvement.

"Violent" or "violence" means acts that meet the criteria for crimes listed in RCW 9.94A.030(32), 9.94A.030(45), 9.94A.030(46), 9.94A.030(54), or 9A.48.040, whether or not the person who committed the acts has been charged with or convicted of the crime.

"Waiver" means the community-based program funded under section 1915(c) of Title XIX of the federal Social Security Act and chapter 388-845 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.210 and Title 71A RCW. 10-11-051, § 388-831-0010, filed 5/12/10, effective 6/12/10. Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0010, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0030 Who are individuals with community protection issues? You are considered an individual with community protection issues if:

(1) You have been determined to have a developmental disability as defined in WAC 388-823-0040 and RCW 71A.10.020(3); and

(2) You have been identified by DDD as a person who meets one or more of the following:

(a) You have been charged with or convicted of a crime of sexual violence as defined in chapter 9A.44 or 71.09 RCW;

(b) You have been charged with or convicted of a crime involving sexual acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization, or persons of casual acquaintance with whom no substantial personal relationship exists;

(c) You have been charged with or convicted of one or more violent crimes as defined in RCW 9.94A.030(45);

(d) You have not been charged with or convicted of a crime identified in (2)(a), (b), or (c) above, but you have a history of violent, stalking, sexually violent, predatory and/or opportunistic behavior which a qualified professional has determined demonstrates a likelihood to commit a violent, sexually violent and/or predatory act; and

(3) You constitute a current risk to others as determined by a qualified professional.

(4) Charges or crimes that result in acquittal are excluded.

[Statutory Authority: RCW 71A.12.030, 71A.12.210 and Title 71A RCW. 10-11-051, § 388-831-0030, filed 5/12/10, effective 6/12/10. Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0030, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0240 Can I be terminated from the community protection program? You may be terminated from the community protection program by the division if:

(1) You physically assault program participants, staff or others;

(2) You repeatedly elope from the program or evade supervision;

(3) You engage in illegal behavior of any kind; or

(4) You refuse to comply with program and/or treatment guidelines to the extent that your therapist determines you are not amenable to treatment; and

(5) The division determines that your health and safety needs cannot be met in the program.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 10-13-166, § 388-831-0240, filed 6/23/10, effective 7/24/10. Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0240, filed 9/30/08, effective 10/31/08.]

Chapter 388-832 WAC
INDIVIDUAL AND FAMILY SERVICES PROGRAM

WAC

388-832-0145 Who is eligible to receive respite care?
388-832-0160 Are there limits to the respite care I receive?
388-832-0305 Who are qualified providers for parent/sibling education?
388-832-0345 Are there limitations to one-time awards?
388-832-0460 How will DDD notify me of decisions?

WAC 388-832-0145 Who is eligible to receive respite care? You are eligible to receive respite care if you are approved for IFS program services and:

(1) You live in your family home and no one living with you is paid to be your caregiver;

(2) You are an adult living in your family home with a parent who provides personal care for you; or

(3) You are an adult living with a family member who has replaced your parent as your primary caregiver and who provides personal care to you.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 71A.12.161. 10-07-122, § 388-832-0145, filed 3/23/10, effective 4/23/10. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0145, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0160 Are there limits to the respite care I receive? The following limitations apply to the respite care you can receive:

(1) Respite cannot replace:

(a) Daycare, childcare or preschool while a parent is at work; and/or

(b) Personal care hours available to you. When determining your unmet need, DDD will first consider the personal care hours available to you.

(2) Respite providers have the following limitations and requirements:

(a) If respite is provided in a private home, the home must be licensed unless it is the client's home or the home of a relative of specified degree per WAC 388-825-345;

(b) The respite provider cannot be the spouse of the caregiver receiving respite if the spouse and the caregiver reside in the same residence; and

(c) If you receive respite from a provider who requires licensure, the respite services are limited to those age-specific services contained in the provider's license.

(d) The respite care provider cannot be your natural, step or adoptive parent living with you.

(3) Your caregiver will not be paid to provide DDD services for you or other persons at the same time you receive respite services.

(4) The need for respite must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

(5) If your personal care provider is your parent, your parent provider may not be paid to provide respite services to any client in the same month that you receive respite services.

(6) Prior approval by the DDD regional administrator or designee is required:

(a) To exceed fourteen days respite care per month; or

(b) To pay for more than eight hours in a twenty-four hour period for respite care in any setting other than your home.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 71A.12.161. 10-07-124, § 388-832-0160, filed 3/23/10, effective 4/23/10. Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0160, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0160, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0305 Who are qualified providers for parent/sibling education? (1) The provider of parent/sibling education must be one of the following licensed, registered or certified professionals and be contracted with DDD for the service specified in the ISP:

(a) Audiologist;

(b) Licensed practical nurse;

(c) Marriage and family therapist;

(d) Mental health counselor;

(e) Occupational therapist;

(f) Physical therapist;

(g) Registered nurse;

(h) Sex offender treatment provider;

(i) Speech/language pathologist;

(j) Social worker;

(k) Psychologist;

(l) Certified American sign language instructor;

(m) Nutritionist;

(n) Registered counselor; or

(o) Certified dietician.

(2) Along with these professional providers, the individual and family services contract, the Arc, Parent to Parent, PAVE and Families Together may be utilized for parent/sibling education.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 71A.12.161. 10-07-124, § 388-832-0305, filed 3/23/10, effective 4/23/10. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0305, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0345 Are there limitations to one-time awards? (1) One-time awards are limited to individuals and families on the IFS request list.

(2) One-time awards are limited to architectural/vehicular modifications or specialized equipment.

(3) One-time awards cannot exceed six thousand dollars in a twenty-four month period.

(4) One-time awards must be approved by the DDD regional administrator or designee.

(5) Eligibility for a one-time award does not guarantee approval and authorization of the service by DDD. Services are based on availability of funding.

(6) One-time awards will be prorated by the number of other members in the household who use these modifications or specialized equipment.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 71A.12.161. 10-07-124, § 388-832-0345, filed 3/23/10, effective 4/23/10. Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0345, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0345, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0460 How will DDD notify me of decisions? Your DDD case resource manager will call you and send a written planned action notice per WAC 388-825-100 to notify you of decisions made.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 71A.12.161. 10-07-124, § 388-832-0460, filed 3/23/10, effective 4/23/10. Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0460, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0460, filed 8/5/08, effective 9/5/08.]

Chapter 388-845 WAC

DDD HOME AND COMMUNITY BASED SERVICES WAIVERS

WAC

388-845-0001	Definitions.
388-845-0015	What HCBS waivers are provided by the division of developmental disabilities (DDD)?
388-845-0020	When were the HCBS waivers effective?
388-845-0030	Do I meet criteria for HCBS waiver-funded services?
388-845-0041	What is DDD's responsibility to provide my services under the DDD HCBS waivers administered by DDD?
388-845-0045	When there is capacity to add people to a waiver, how does DDD determine who will be enrolled?
388-845-0050	How do I request to be enrolled in a waiver?
388-845-0055	How do I remain eligible for the waiver?
388-845-0065	What happens if I am terminated or choose to disenroll from a waiver?
388-845-0100	What determines which waiver I am assigned to?
388-845-0111	Are there limitations regarding who can provide services?
388-845-0120	Will I continue to receive state supplementary payments (SSP) if I am on the waiver?
388-845-0200	What waiver services are available to me?
388-845-0225	Children's intensive in-home behavioral support (CIIBS) waiver services.
388-845-0415	What is assistive technology?
388-845-0420	Who is a qualified provider of assistive technology?
388-845-0425	Are there limits to the assistive technology I can receive?
388-845-0500	What is behavior management and consultation?
388-845-0501	What is included in behavior management and consultation for the children's intensive in-home behavioral support (CIIBS) waiver?
388-845-0505	Who is a qualified provider of behavior management and consultation?
388-845-0506	Who is a qualified provider of behavior management and consultation for the children's intensive in-home behavioral supports (CIIBS) waiver?
388-845-0900	What are environmental accessibility adaptations?
388-845-0910	What limitations apply to environmental accessibility adaptations?
388-845-1000	What are extended state plan services?

388-845-1015	Are there limits to the extended state plan services I can receive?
388-845-1110	What are the limits of mental health crisis diversion bed services?
388-845-1150	What are mental health stabilization services?
388-845-1170	What is nurse delegation?
388-845-1175	Who is a qualified provider of nurse delegation?
388-845-1180	Are there limitations to the nurse delegation services that I receive?
388-845-1200	What are "person-to-person" services?
388-845-1300	What are personal care services?
388-845-1400	What are prevocational services?
388-845-1600	What is respite care?
388-845-1605	Who is eligible to receive respite care?
388-845-1620	Are there limits to the respite care I can receive?
388-845-1650	What are sexual deviancy evaluations?
388-845-1700	What is skilled nursing?
388-845-1800	What are specialized medical equipment and supplies?
388-845-1840	What is specialized nutrition and specialized clothing?
388-845-1845	Who are qualified providers of specialized nutrition and specialized clothing?
388-845-1850	Are there limitations to my receipt of specialized nutrition and specialized clothing?
388-845-1900	What are specialized psychiatric services?
388-845-2000	What is staff/family consultation and training?
388-845-2005	Who is a qualified provider of staff/family consultation and training?
388-845-2100	What are supported employment services?
388-845-2160	What is therapeutic equipment and supplies?
388-845-2165	Who are qualified providers of therapeutic equipment and supplies?
388-845-2170	Are there limitations on my receipt of therapeutic equipment and supplies?
388-845-2200	What are transportation services?
388-845-2260	What are vehicle modifications?
388-845-2265	Who are providers of vehicle modifications?
388-845-2270	Are there limitations to my receipt of vehicle modification services?
388-845-3000	What is the process for determining the services I need?
388-845-3085	What if my needs exceed what can be provided under the CIIBS, Core or Community Protection waiver?
388-845-4005	Can I appeal a denial of my request to be enrolled in a waiver?

WAC 388-845-0001 Definitions. "ADSA" means the aging and disability services administration, an administration within the department of social and health services.

"Aggregate services" means a combination of services subject to the dollar limitations in the Basic and Basic Plus waivers.

"CARE" means the comprehensive assessment and reporting evaluation.

"Client or person" means a person who has a developmental disability as defined in RCW 71A.10.020(3) and has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration of the department of social and health services.

"DDD assessment" refers to the standardized assessment tool as defined in chapter 388-828 WAC, used by DDD to measure the support needs of persons with developmental disabilities.

"Department" means the department of social and health services.

"EPSDT" means early and periodic screening, diagnosis, and treatment, medicaid's child health component providing a mandatory and comprehensive set of benefits and services for children up to age twenty one as defined in WAC 388-534-0100.

"Employment/day program services" means community access, person-to-person, prevocational services or supported employment services subject to the dollar limitations in the Basic and Basic Plus waivers.

"Evidence based treatment" means the use of physical, mental and behavioral health interventions for which systematic, empirical research has provided evidence of statistically significant effectiveness as treatments for specific conditions. Alternate terms with the same meaning are evidence-based practice (EBP) and empirically supported treatment (EST).

"Family" means relatives who live in the same home with the eligible client. Relatives include spouse or registered domestic partner; natural, adoptive or step parent; grandparent; child; stepchild; sibling; stepsibling; uncle; aunt; first cousin; niece; or nephew.

"Family home" means the residence where you and your relatives live.

"Gainful employment" means employment that reflects achievement of or progress towards a living wage.

"HCBS waivers" means home and community based services waivers.

"Home" means present or intended place of residence.

"ICF/MR" means an intermediate care facility for the mentally retarded.

"Individual support plan (ISP)" is a document that authorizes and identifies the DDD paid services to meet a client's assessed needs.

"Integrated settings" mean typical community settings not designed specifically for individuals with disabilities in which the majority of persons employed and participating are individuals without disabilities.

"Legal representative" means a parent of a person who is under eighteen years of age, a person's legal guardian, a person's limited guardian when the subject matter is within the scope of limited guardianship, a person's attorney at law, a person's attorney in fact, or any other person who is authorized by law to act for another person.

"Living wage" means the amount of earned wages needed to enable an individual to meet or exceed his/her living expenses.

"Necessary supplemental accommodation representative" means an individual who receives copies of DDD planned action notices (PANs) and other department correspondence in order to help a client understand the documents and exercise the client's rights. A necessary supplemental accommodation representative is identified by a client of DDD when the client does not have a legal guardian and the client is requesting or receiving DDD services.

"Providers" means an individual or agency who meets the provider qualifications and is contracted with ADSA to provide services to you.

"Respite assessment" means an algorithm within the DDD assessment that determines the number of hours of respite care you may receive per year if you are enrolled in the Basic, Basic Plus, Children's Intensive In-Home Behavioral Support, or Core waiver.

"SSI" means Supplemental Security Income, an assistance program administered by the federal Social Security Administration for blind, disabled and aged individuals.

"SSP" means a state-paid cash assistance program for certain clients of the division of developmental disabilities.

"State funded services" means services that are funded entirely with state dollars.

"You/your" means the client.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0001, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 08-20-033, § 388-845-0001, filed 9/22/08, effective 10/23/08; 07-20-050, § 388-845-0001, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0001, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0015 What HCBS waivers are provided by the division of developmental disabilities (DDD)? DDD provides services through five HCBS waivers:

(1) Basic waiver;

(2) Basic Plus waiver;

(3) Core waiver;

(4) Community Protection waiver; and

(5) Children's Intensive In-Home Behavioral Support waiver (CIIBS).

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0015, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0015, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0020 When were the HCBS waivers effective? Basic, Basic Plus, Core and Community Protection waivers were effective April 1, 2004. Children's Intensive In-Home Behavioral Support waiver was effective May 1, 2009.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0020, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0020, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0030 Do I meet criteria for HCBS waiver-funded services? You meet criteria for DDD HCBS waiver-funded services if you meet all of the following:

(1) You have been determined eligible for DDD services per RCW 71A.10.020(3).

(2) You have been determined to meet ICF/MR level of care per WAC 388-845-0070, 388-828-3060 and 388-828-3080.

(3) You meet disability criteria established in the Social Security Act.

(4) You meet financial eligibility requirements as defined in WAC 388-515-1510.

(5) You choose to receive services in the community rather than in an ICF/MR facility.

(6) You have a need for waiver services as identified in your plan of care or individual support plan.

(7) You are not residing in hospital, jail, prison, nursing facility, ICF/MR, or other institution.

(8) Additionally, for the Children's Intensive In-Home Behavioral Support (CIIBS) waiver-funded services:

(a) You are age eight or older and under the age of eighteen for initial enrollment and under age twenty-one for continued enrollment;

(b) You have been determined to meet CIIBS program eligibility per chapter 388-828 WAC prior to initial enrollment only;

(c) You live with your family; and

(d) Your parent/guardian(s) and primary caregiver(s), if other than parent/guardian(s), have signed the participation agreement.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0030, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0030, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0030, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0041 What is DDD's responsibility to provide my services under the DDD HCBS waivers administered by DDD? If you are enrolled in an HCBS waiver administered by DDD, DDD must meet your assessed needs for health and welfare.

(1) DDD must address your assessed health and welfare needs in your individual support plan, as specified in WAC 388-845-3055.

(2) You have access to DDD paid services that are provided within the scope of your waiver, subject to the limitations in WAC 388-845-0110 and 388-845-0115.

(3) DDD will provide waiver services you need and qualify for within your waiver.

(4) DDD will not deny or limit your waiver services based on a lack of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0041, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0041, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0041, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0045 When there is capacity to add people to a waiver, how does DDD determine who will be enrolled? When there is capacity on a waiver and available funding for new waiver participants, DDD may enroll people from the statewide data base in a waiver based on the following priority considerations:

(1) First priority will be given to current waiver participants assessed to require a different waiver because their identified health and welfare needs have increased and these needs cannot be met within the scope of their current waiver.

(2) DDD may also consider any of the following populations in any order:

(a) Priority populations as identified and funded by the legislature.

(b) Persons DDD has determined to be in immediate risk of ICF/MR admission due to unmet health and welfare needs.

(c) Persons identified as a risk to the safety of the community.

(d) Persons currently receiving services through state-only funds.

(e) Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified health and welfare needs.

(f) Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility per WAC 388-845-0060 (1)(i).

(3) For the Basic waiver only, DDD may consider persons who need the waiver services available in the Basic waiver to maintain them in their family's home or in their own home.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0045, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 08-20-033, § 388-845-0045, filed 9/22/08, effective 10/23/08; 07-20-050, § 388-845-0045, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0045, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0050 How do I request to be enrolled in a waiver? (1) You can contact DDD and request to be enrolled in a waiver or to enroll in a different waiver at any time.

(2) If you are assessed as meeting ICF/MR level of care as defined in WAC 388-845-0070 and chapter 388-828 WAC, your request for waiver enrollment will be documented by DDD in a statewide data base.

(3) For the Children's Intensive In-Home Behavioral Support (CIIBS) waiver only, if you are assessed as meeting both ICF/MR level of care and CIIBS eligibility as defined in WAC 388-845-0030 and chapter 388-828 WAC, your request for waiver enrollment will be documented by DDD in a statewide data base.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0050, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0050, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0055 How do I remain eligible for the waiver? Once you are enrolled in a DDD HCBS waiver, you can remain eligible if you continue to meet eligibility criteria in WAC 388-845-0030, and:

(1) You complete a reassessment with DDD at least once every twelve months to determine if you continue to meet all of these eligibility requirements; and

(2) You must either receive a waiver service at least once in every thirty consecutive days, as specified in WAC 388-513-1320 (3)(b), or your health and welfare needs require monthly monitoring, which will be documented in your client record; and

(3) You complete an in-person DDD assessment/reassessment interview administered in your home per WAC 388-828-1520.

(4) In addition, for the Children's Intensive In-Home Behavioral Supports waiver, you must:

(a) Be under age twenty-one;

(b) Live with your family; and

(c) Have an annual participation agreement signed by your parent/guardian(s) and primary caregiver(s), if other than parent/guardian(s).

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0055, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0055, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0055, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0065 What happens if I am terminated or choose to disenroll from a waiver? If you are terminated from a waiver or choose to disenroll from a waiver, DDD will notify you.

(1) DDD cannot guarantee continuation of your current services, including medicaid eligibility.

(2) Your eligibility for nonwaiver state-only funded DDD services is based upon availability of funding and program eligibility for a particular service.

(3) If you are terminated from the CIIBS waiver due to turning age twenty-one, DDD will assist with transition planning at least twelve months prior to your twenty-first birthday.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0065, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0065, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0100 What determines which waiver I am assigned to? If there is capacity, DDD will assign you to the waiver with the minimum service package necessary to meet your health and welfare needs, based on its evaluation of your DDD assessment as described in chapter 388-828 WAC and the following criteria:

(1) For the Basic waiver:

(a) You must live with your family or in your own home;

(b) Your family/caregiver's ability to continue caring for you can be maintained with the addition of services provided in the Basic waiver; and

(c) You do not need out-of-home residential services.

(2) For the Basic Plus waiver, your health and welfare needs exceed the amount allowed in the Basic waiver or require a service that is not contained in the Basic waiver; and

(a) You are at high risk of out-of-home placement or loss of your current living situation; or

(b) You require out-of-home placement and your health and welfare needs can be met in an adult family home or adult residential care facility.

(3) For the Core waiver:

(a) You are at immediate risk of out-of-home placement; and/or

(b) You have an identified health and welfare need for residential services that cannot be met by the Basic Plus waiver.

(4) For the Community Protection waiver, refer to WAC 388-845-0105 and chapter 388-831 WAC.

(5) For the Children's Intensive In-Home Behavioral Support waiver, you:

(a) Are age eight or older and under age eighteen;

(b) Live with your family;

(c) Are assessed at high or severe risk of out of home placement due to challenging behavior per chapter 388-828 WAC; and

(d) You have a signed participation agreement from your parent/guardian(s) and primary caregiver(s), if other than parent/guardian(s).

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0100, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0100, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0111 Are there limitations regarding who can provide services? The following limitations apply to providers for waiver services:

(1) Your spouse must not be your paid provider for any waiver service.

(2) If you are under age eighteen, your natural, step, or adoptive parent must not be your paid provider for any waiver service.

(3) If you are age eighteen or older, your natural, step, or adoptive parent must not be your paid provider for any waiver service with the exception of:

(a) Personal care;

(b) Transportation to and from a waiver service;

(c) Residential habilitation services per WAC 388-845-1510 if your parent is certified as a residential agency per chapter 388-101 WAC; or

(d) Respite care if you and the parent who provides the respite care live in separate homes.

(4) If you receive CIIBS waiver services, your legal representative or family member per WAC 388-845-0001 must not be your paid provider for any waiver service with the exception of:

(a) Personal care;

(b) Transportation to and from a waiver service; and

(c) Respite per WAC 388-845-1605 through 388-845-1620.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0111, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0111, filed 9/26/07, effective 10/27/07.]

WAC 388-845-0120 Will I continue to receive state supplementary payments (SSP) if I am on the waiver? Your participation in one of the DDD HCBS waivers does not affect your continued receipt of state supplemental payment from DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0120, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0120, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0200 What waiver services are available to me? Each of the DDD HCBS waivers has a different scope of service and your individual support plan defines the waiver services available to you.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0200, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0200, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0225 Children's intensive in-home behavioral support (CIIBS) waiver services.

CIIBS Waiver	Services	Yearly Limit
	• Behavior management and consultation • Staff/family consultation and training • Environmental accessibility adaptations • Occupational therapy • Physical therapy • Sexual deviancy evaluation • Nurse delegation • Specialized medical equipment / supplies • Specialized psychiatric services • Speech, hearing and language services • Transportation • Assistive technology • Therapeutic equipment and supplies • Specialized nutrition and clothing • Vehicle modifications	Determined by the individual support plan. Total cost of waiver services cannot exceed the average cost of $4,000 per month per participant.
	Personal care	Limits determined by the DDD assessment. Costs are included in the total average cost of $4000 per month per participant for all waiver services.
	Respite care	Limits determined by the DDD assessment. Costs are included in the total average cost of $4000 per month per participant for all waiver services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0225, filed 11/1/10, effective 12/2/10.]

WAC 388-845-0415 What is assistive technology? Assistive technology consists of items, equipment, or product systems used to increase, maintain, or improve functional capabilities of waiver participants, as well as services to directly assist the participant and caregivers to select, acquire, and use the technology. Assistive technology is available in the CIIBS waiver, and includes the following:

(1) The evaluation of the needs of the waiver participant, including a functional evaluation of the child in the child's customary environment;

(2) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices;

(3) Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devices;

(4) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(5) Training or technical assistance for the participant and/or if appropriate, the child's family; and

(6) Training or technical assistance for professionals, including individuals providing education and rehabilitation services, employers, or other individuals who provide services to, employ, or are otherwise involved in the assistive technology related life functions of children with disabilities.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0415, filed 11/1/10, effective 12/2/10.]

WAC 388-845-0420 Who is a qualified provider of assistive technology? The provider of assistive technology must be an assistive technology vendor contracted with DDD or one of the following professionals contracted with DDD and duly licensed, registered or certified to provide this service:

(1) Occupational therapist;

(2) Physical therapist;

(3) Speech and language pathologist;

(4) Certified music therapist;

(5) Certified recreation therapist; or

(6) Audiologist.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0420, filed 11/1/10, effective 12/2/10.]

WAC 388-845-0425 Are there limits to the assistive technology I can receive? (1) Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDD for the therapy they are providing.

(2) Vendors of assistive technology must maintain a business license required by law and be contracted with DDD to provide this service.

(3) Assistive technology may be authorized as a waiver service by obtaining an initial denial of funding or information showing that the technology is not covered by medicaid or private insurance.

(4) The department does not pay for experimental technology.

(5) The department requires your treating professional's written recommendation regarding your need for the technology. This recommendation must take into account that:

(a) The treating professional has personal knowledge of and experience with the requested and alternative technology; and

(b) The treating professional has recently examined you, reviewed your medical records, and conducted a functional evaluation.

(6) The department may require a written second opinion from a department selected professional that meets the same criteria in subsection (5) above.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0425, filed 11/1/10, effective 12/2/10.]

WAC 388-845-0500 What is behavior management and consultation? (1) Behavior management and consultation may be provided to persons on any of the DDD HCBS waivers and includes the development and implementation of programs designed to support waiver participants using:

(a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and

(b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise their ability to remain in the community (i.e., training, specialized cognitive counseling, development and implementation of a positive behavior support plan).

(2) Behavior management and consultation may also be provided as a mental health stabilization service in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0500, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0500, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0501 What is included in behavior management and consultation for the children's intensive in-home behavioral support (CIIBS) waiver? (1) In addition to the definition in WAC 388-845-0500, behavior management and consultation in the CIIBS waiver must include the following characteristics:

(a) Treatment must be evidence based, driven by individual outcome data, and consistent with DDD's positive behavior support guidelines as outlined in contract;

(b) The following written components will be developed in partnership with the child and family by a behavior specialist as defined in WAC 388-845-0506:

(i) Functional behavioral assessment; and

(ii) Positive behavior support plan based on functional behavioral assessment.

(c) Treatment goals must be objective and measurable. The goals must relate to an increase in skill development and a resulting decrease in challenging behaviors that impede quality of life for the child and family; and

(d) Behavioral support strategies will be individualized and coordinated across all environments, such as home, school, and community, in order to promote a consistent approach among all involved persons.

(2) Behavior management and consultation in the CIIBS waiver may also include the following components:

(a) Positive behavior support plans may be implemented by a behavioral technician as defined in WAC 388-845-0506 and include 1:1 behavior interventions and skill development activity.

(b) Positive behavior support plans may include recommendations by a music and/or recreation therapist, as defined in WAC 388-845-0506.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0501, filed 11/1/10, effective 12/2/10.]

WAC 388-845-0505 Who is a qualified provider of behavior management and consultation? Under the Basic, Basic Plus, Core, and Community Protection waivers, the provider of behavior management and consultation must be one of the following professionals contracted with DDD and duly licensed, registered or certified to provide this service:

(1) Marriage and family therapist;

(2) Mental health counselor;

(3) Psychologist;

(4) Sex offender treatment provider;

(5) Social worker;

(6) Registered nurse (RN) or licensed practical nurse (LPN);

(7) Psychiatrist;

(8) Psychiatric advanced registered nurse practitioner (ARNP);

(9) Physician assistant working under the supervision of a psychiatrist;

(10) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW; or

(11) Polygrapher.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0505, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0505, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0506 Who is a qualified provider of behavior management and consultation for the children's intensive in-home behavioral supports (CIIBS) waiver? (1) Under the CIIBS waiver, providers of behavior management and consultation must be contracted with DDD to provide CIIBS intensive services as one of the following four provider types:

(a) Master's or PhD level behavior specialist, licensed or certified/registered to provide behavioral assessment, intervention, and training;

(b) Behavior technician, licensed or certified/registered to provide behavioral intervention and training, following the lead of the behavior specialist;

(c) Certified music therapist; and/or

(d) Certified recreation therapist.

(2) Providers of behavior management and consultation per WAC 388-845-0505 may be utilized to provide counseling and/or therapy services to augment the work of the CIIBS intensive service provider types.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0506, filed 11/1/10, effective 12/2/10.]

WAC 388-845-0900 What are environmental accessibility adaptations? (1) Environmental accessibility adaptations are available in all of the DDD HCBS waivers and provide the physical adaptations to the home required by the individual's plan of care or individual support plan needed to:

(a) Ensure the health, welfare and safety of the individual; or

(b) Enable the individual who would otherwise require institutionalization to function with greater independence in the home.

(2) Environmental accessibility adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

(3) For the CIIBS waiver only, adaptations include repairs to the home necessary due to property destruction caused by the participant's behavior.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0900, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0900, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0900, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0910 What limitations apply to environmental accessibility adaptations? The following service limitations apply to environmental accessibility adaptations:

(1) Environmental accessibility adaptations require prior approval by the DDD regional administrator or designee.

(2) With the exception of damage repairs under the CIIBS waiver, environmental accessibility adaptations or improvements to the home are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

(3) Environmental accessibility adaptations cannot add to the total square footage of the home.

(4) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

(5) Damage repairs under the CIIBS waiver are subject to the following restrictions:

(a) Limited to the cost of restoration to the original condition.

(b) Repairs to personal property and normal wear and tear are excluded.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-0910, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-0910, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0910, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1000 What are extended state plan services? Extended state plan services refer to physical therapy; occupational therapy; and speech, hearing and language services available to you under medicaid without regard to your waiver status. They are "extended" services when the waiver pays for more services than is provided under the state medicaid plan. These services are available under all DDD HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1000, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1015 Are there limits to the extended state plan services I can receive? (1) Additional therapy may be authorized as a waiver service only after you have accessed what is available to you under medicaid and any other private health insurance plan;

(2) The department does not pay for treatment determined by DSHS to be experimental;

(3) The department and the treating professional determine the need for and amount of service you can receive:

(a) The department may require a second opinion from a department selected provider.

(b) The department will require evidence that you have accessed your full benefits through medicaid before authorizing this waiver service.

(4) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1015, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1110 What are the limits of mental health crisis diversion bed services? (1) Mental health crisis diversion bed services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a mental health professional and/or DDD.

(2) These services are available in the Basic, Basic Plus, Core, and Community Protection waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

(3) The costs of mental health crisis diversion bed services do not count toward the dollar limits for aggregate services in the Basic and Basic Plus waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1110, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1110, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1150 What are mental health stabilization services? Mental health stabilization services assist persons who are experiencing a mental health crisis. These services are available in the Basic, Basic Plus, Core, and Community Protection waivers to adults determined by mental health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without one of more of the following services:

(1) Behavior management and consultation;

(2) Specialized psychiatric services; or

(3) Mental health crisis diversion bed services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1150, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1150, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1170 What is nurse delegation? (1) Nurse delegation services are services in compliance with WAC 246-840-910 through 246-840-970 by a registered nurse to provide training and nursing management for nursing assistants who perform delegated nursing tasks.

(2) Delegated nursing tasks include, but are not limited to, administration of noninjectable medications except for insulin, blood glucose testing, and tube feedings.

(3) Services include the initial visit, care planning, competency testing of the nursing assistant, consent of the client, additional instruction and supervisory visits.

(4) Clients who receive nurse delegation services must be considered "stable and predictable" by the delegated nurse.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1170, filed 11/1/10, effective 12/2/10.]

WAC 388-845-1175 Who is a qualified provider of nurse delegation? Providers of nurse delegation are registered nurses contracted with DDD to provide this service or employed by a nursing agency contracted with DDD to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1175, filed 11/1/10, effective 12/2/10.]

WAC 388-845-1180 Are there limitations to the nurse delegation services that I receive? The following limitations apply to receipt of nurse delegation services:

(1) The department requires the delegating nurse's written recommendation regarding your need for the service. This recommendation must take into account that the nurse has recently examined you, reviewed your medical records, and conducted a nursing assessment.

(2) The department may require a written second opinion from a department selected nurse delegator that meets the same criteria in subsection (1) of this section.

(3) The following tasks must not be delegated:

(a) Injections, other than insulin;

(b) Central lines;

(c) Sterile procedures; and

(d) Tasks that require nursing judgment.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1180, filed 11/1/10, effective 12/2/10.]

WAC 388-845-1200 What are "person-to-person" services? (1) "Person-to-person" services are intended to assist you to achieve the outcome of gainful employment in an integrated setting through a combination of services, which may include:

(a) Development and implementation of self-directed employment services;

(b) Development of a person centered employment plan;

(c) Preparation of an individualized budget; and

(d) Support to work and volunteer in the community, and/or access the generic community resources needed to achieve integration and employment.

(2) These services may be provided in addition to community access, prevocational services, or supported employment.

(3) These services are available in the Basic, Basic Plus, Core and Community Protection waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1200, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 08-20-033, § 388-845-1200, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1300 What are personal care services? Personal care services as defined in WAC 388-106-0010 are the provision of assistance with personal care tasks. These services are available in the Basic, Basic Plus, CIIBS and Core waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1300, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-1300, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1300, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1400 What are prevocational services? (1) Prevocational services occur in a segregated setting and are designed to prepare you for gainful employment in an integrated setting through training and skill development.

(2) Prevocational services are available in the Basic, Basic Plus, Core and Community Protection waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1400, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 08-20-033, § 388-845-1400, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1400, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1600 What is respite care? Respite care is short-term intermittent relief for persons normally providing care for waiver individuals. This service is available in the Basic, Basic Plus, CIIBS, and Core waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1600, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 08-20-033, § 388-845-1600, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1600, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1605 Who is eligible to receive respite care? You are eligible to receive respite care if you are in the Basic, Basic Plus, CIIBS or Core waiver and:

(1) You live in a private home and no one living with you is paid to provide personal care services to you;

(2) You are age eighteen or older and live with a paid personal care provider who is your natural, step or adoptive parent; or

(3) You are under the age of eighteen and live with your natural, step or adoptive parent and your paid personal care provider also lives with you; or

(4) You live with a caregiver who is paid by DDD to provide supports as:

(a) A contracted companion home provider; or

(b) A licensed children's foster home provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1605, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.30 [71A.12.-030], 71A.12.120, and Title 71A RCW. 08-03-109, § 388-845-1605, filed 1/22/08, effective 2/22/08. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1605, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1620 Are there limits to the respite care I can receive? The following limitations apply to the respite care you can receive:

(1) The DDD assessment will determine how much respite you can receive per chapter 388-828 WAC.

(2) Prior approval by the DDD regional administrator or designee is required:

(a) To exceed fourteen days of respite care per month; or

(b) To pay for more than eight hours in a twenty-four hour period of time for respite care in any setting other than your home or place of residence. This limitation does not prohibit your respite care provider from taking you into the community, per WAC 388-845-1610(2).

(3) Respite cannot replace:

(a) Daycare while your parent or guardian is at work; and/or

(b) Personal care hours available to you. When determining your unmet need, DDD will first consider the personal care hours available to you.

(4) Respite providers have the following limitations and requirements:

(a) If respite is provided in a private home, the home must be licensed unless it is the client's home or the home of a relative of specified degree per WAC 388-825-345;

(b) The respite provider cannot be the spouse of the caregiver receiving respite if the spouse and the caregiver reside in the same residence; and

(c) If you receive respite from a provider who requires licensure, the respite services are limited to those age-specific services contained in the provider's license.

(5) Your caregiver may not provide DDD services for you or other persons during your respite care hours.

(6) If your personal care provider is your parent, your parent provider will not be paid to provide respite services to any client in the same month that you receive respite services.

(7) DDD may not pay for any fees associated with the respite care; for example, membership fees at a recreational facility, or insurance fees.

(8) If you require respite from a licensed practical nurse (LPN) or a registered nurse (RN), services may be authorized as skilled nursing services per WAC 388-845-1700 using an LPN or RN. If you are in the Basic Plus waiver, skilled nursing services are limited to the dollar limits of your aggregate services per WAC 388-845-0210.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1620, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-

120 and Title 71A RCW. 08-20-033, § 388-845-1620, filed 9/22/08, effective 10/23/08; 07-20-050, § 388-845-1620, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1620, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1650 What are sexual deviancy evaluations? (1) Sexual deviancy evaluations:

(a) Are professional evaluations that assess the person's needs and the person's level of risk of sexual offending or sexual recidivism;

(b) Determine the need for psychological, medical or therapeutic services; and

(c) Provide treatment recommendations to mitigate any assessed risk.

(2) Sexual deviancy evaluations are available in all DDD HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1650, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1650, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1650, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1700 What is skilled nursing? (1) Skilled nursing is continuous, intermittent, or part time nursing services. These services are available in the Basic Plus, Core, and Community Protection waivers.

(2) Services include nurse delegation services, per WAC 388-845-1170, provided by a registered nurse, including the initial visit, follow-up instruction, and/or supervisory visits.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1700, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.120 and chapter 71A.12 RCW. 06-01-024, § 388-845-1700, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1800 What are specialized medical equipment and supplies? (1) Specialized medical equipment and supplies are durable and nondurable medical equipment not available through medicaid or the state plan which enables individuals to:

(a) Increase their abilities to perform their activities of daily living; or

(b) Perceive, control or communicate with the environment in which they live.

(2) Durable and nondurable medical equipment are defined in WAC 388-543-1000 and 388-543-2800 respectively.

(3) Also included are items necessary for life support; and ancillary supplies and equipment necessary to the proper functioning of the equipment and supplies described in subsection (1) above.

(4) Specialized medical equipment and supplies are available in all DDD HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1800, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1800, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1800, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1840 What is specialized nutrition and specialized clothing? (1) Specialized nutrition is available to you in the CIIBS waiver and is defined as:

(a) Assessment, intervention, and monitoring services from a certified dietitian; and/or

(b) Specially prepared food, or purchase of particular types of food, needed to sustain you in the family home. Specialized nutrition is in addition to meals a parent would provide and specific to your medical condition or diagnosis.

(2) Specialized clothing is available to you in the CIIBS waiver and defined as nonrestrictive clothing adapted to the participant's individual needs and related to his/her disability. Specialized clothing can include weighted clothing, clothing designed for tactile defensiveness, specialized footwear, or reinforced clothing.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1840, filed 11/1/10, effective 12/2/10.]

WAC 388-845-1845 Who are qualified providers of specialized nutrition and specialized clothing? (1) Providers of specialized nutrition are:

(a) Certified dietitians contracted with DDD to provide this service or employed by an agency contracted with DDD to provide this service; and

(b) Specialized nutrition vendors contracted with DDD to provide this service.

(2) Providers of specialized clothing are specialized clothing vendors contracted with DDD to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1845, filed 11/1/10, effective 12/2/10.]

WAC 388-845-1850 Are there limitations to my receipt of specialized nutrition and specialized clothing? (1) The following limitations apply to your receipt of specialized nutrition services:

(a) Services may be authorized as a waiver service only after you have accessed what is available to you under medicaid including EPSDT per WAC 388-534-0100, and any private health insurance plan;

(b) Services must be evidence based;

(c) Services must be ordered by a physician licensed to practice in the state of Washington;

(d) Specialized diets must be periodically monitored by a certified dietitian;

(e) Specialized nutrition products will not constitute a full nutritional regime unless an enteral diet is the primary source of nutrition;

(f) Department coverage of specialized nutrition products is limited to costs that are over and above inherent family food costs;

(g) DDD reserves the right to require a second opinion by a department selected provider; and

(h) Prior approval by regional administrator or designee is required.

(2) The following limitations apply to your receipt of specialized clothing:

(a) Services may be authorized as a waiver service only after you have accessed what is available to you under med-

icaid, EPSDT per WAC 388-534-0100, and any private health insurance plan;

(b) Specialized clothing must be recommended by an appropriate health professional, such as an OT, behavior therapist, or podiatrist;

(c) DDD reserves the right to require a second opinion by a department-selected provider; and

(d) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1850, filed 11/1/10, effective 12/2/10.]

WAC 388-845-1900 What are specialized psychiatric services? (1) Specialized psychiatric services are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms. These services are available in all DDD HCBS waivers.

(2) Service may be any of the following:

(a) Psychiatric evaluation,

(b) Medication evaluation and monitoring,

(c) Psychiatric consultation.

(3) These services are also available as a mental health stabilization service in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-1900, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1900, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2000 What is staff/family consultation and training? (1) Staff/family consultation and training is professional assistance to families or direct service providers to help them better meet the needs of the waiver person. This service is available in all DDD HCBS waivers.

(2) Consultation and training is provided to families, direct staff, or personal care providers to meet the specific needs of the waiver participant as outlined in the individual's plan of care or individual support plan, including:

(a) Health and medication monitoring;

(b) Positioning and transfer;

(c) Basic and advanced instructional techniques;

(d) Positive behavior support;

(e) Augmentative communication systems;

(f) Diet and nutritional guidance;

(g) Disability information and education;

(h) Strategies for effectively and therapeutically interacting with the participant;

(i) Environmental consultation; and

(j) For the CIIBS waiver only, individual and family counseling.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2000, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-2000, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training? To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDD:

(1) Audiologist;

(2) Licensed practical nurse;

(3) Marriage and family therapist;

(4) Mental health counselor;

(5) Occupational therapist;

(6) Physical therapist;

(7) Registered nurse;

(8) Sex offender treatment provider;

(9) Speech/language pathologist;

(10) Social worker;

(11) Psychologist;

(12) Certified American sign language instructor;

(13) Nutritionist;

(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;

(15) Certified dietician;

(16) Recreation therapist certified by the National Council for Therapeutic Recreation; or

(17) Providers listed in WAC 388-845-0506 and contracted with DDD to provide CIIBS intensive services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2005, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-2005, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2005, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2100 What are supported employment services? Supported employment services provide you with intensive ongoing support if you need individualized assistance to gain and/or maintain employment. These services are tailored to your individual needs, interests, abilities, and promote your career development. These services are provided in individual or group settings and are available in the Basic, Basic Plus, Core and Community Protection waivers.

(1) Individual supported employment services include activities needed to sustain minimum wage pay or higher. These services are conducted in integrated business environments and include the following:

(a) Creation of work opportunities through job development;

(b) On-the-job training;

(c) Training for your supervisor and/or peer workers to enable them to serve as natural supports to you on the job;

(d) Modification of your work site tasks;

(e) Employment retention and follow along support; and

(f) Development of career and promotional opportunities.

(2) Group supported employment services are a step on your pathway toward gainful employment in an integrated setting and include:

(a) The activities outlined in individual supported employment services;

(b) Daily supervision by a qualified employment provider; and

(c) Groupings of no more than eight workers with disabilities.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2100, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 08-20-033, § 388-845-2100, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2160 What is therapeutic equipment and supplies? (1) Therapeutic equipment and supplies are only available in the CIIBS waiver.

(2) Therapeutic equipment and supplies are equipment and supplies that are incorporated in a behavioral support plan or other therapeutic plan, designed by an appropriate professional, such as a sensory integration or communication therapy plan, and necessary in order to fully implement the therapy or intervention.

(3) Included are items such as a weighted blanket, supplies that assist to calm or redirect the child to a constructive activity, or a vestibular swing.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2160, filed 11/1/10, effective 12/2/10.]

WAC 388-845-2165 Who are qualified providers of therapeutic equipment and supplies? Providers of therapeutic equipment and supplies are therapeutic equipment and supply vendors contracted with DDD to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2165, filed 11/1/10, effective 12/2/10.]

WAC 388-845-2170 Are there limitations on my receipt of therapeutic equipment and supplies? The following limitations apply to your receipt of therapeutic equipment and supplies under the CIIBS waiver:

(1) Therapeutic equipment and supplies may be authorized as a waiver service only after you have accessed what is available to you under medicaid including EPSDT per WAC 388-534-0100, and any private health insurance plan. The department will require evidence that you have accessed your full benefits through medicaid, EPSDT, and private insurance before authorizing this waiver service.

(2) The department does not pay for experimental equipment and supplies.

(3) The department requires your treating professional's written recommendation regarding your need for the service. This recommendation must take into account that the treating professional has recently examined you, reviewed your medical records, and conducted a functional evaluation.

(4) The department may require a written second opinion from a department selected professional that meets the same criteria in subsection (3) of this section.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2170, filed 11/1/10, effective 12/2/10.]

WAC 388-845-2200 What are transportation services? Transportation services provide reimbursement to a provider when the transportation is required and specified in the waiver plan of care or individual support plan. This service is available in all DDD HCBS waivers if the cost and responsibility for transportation is not already included in your provider's contract and payment.

(1) Transportation provides you access to waiver services, specified by your plan of care or individual support plan.

(2) Whenever possible, you must use family, neighbors, friends, or community agencies that can provide this service without charge.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2200, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-2200, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2260 What are vehicle modifications? This service is only available in the CIIBS waiver. Vehicle modifications are adaptations or alterations to a vehicle required in order to accommodate the unique needs of the individual, enable full integration into the community, and ensure the health, welfare, and safety of the individual and/or family members.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2260, filed 11/1/10, effective 12/2/10.]

WAC 388-845-2265 Who are providers of vehicle modifications? Providers of vehicle modifications are:

(1) Vehicle service providers contracted with DDD to provide this service; or

(2) Vehicle adaptive equipment vendors contracted with DDD to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2265, filed 11/1/10, effective 12/2/10.]

WAC 388-845-2270 Are there limitations to my receipt of vehicle modification services? The following limitations apply to your receipt of vehicle modifications under the CIIBS waiver:

(1) Prior approval by the regional administrator or designee is required.

(2) Vehicle modifications are excluded if they are of general utility without direct medical or remedial benefit to the individual.

(3) Vehicle modifications must be the most cost effective modification based upon a comparison of contractor bids as determined by DDD.

(4) Modifications will only be approved for a vehicle that serves as the participant's primary means of transportation and is owned by the family.

(5) The department requires your treating professional's written recommendation regarding your need for the service. This recommendation must take into account that the treating professional has recently examined you, reviewed your medical records, and conducted a functional evaluation.

(6) The department may require a second opinion from a department selected provider that meets the same criteria as subsection (5) of this section.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-2270, filed 11/1/10, effective 12/2/10.]

WAC 388-845-3000 What is the process for determining the services I need? Your service needs are determined through the DDD assessment and the service planning process as defined in chapter 388-828 WAC. Only identified health and welfare needs will be authorized for payment in the ISP.

(1) You receive an initial and annual assessment of your needs using a department-approved form.

(a) You meet the eligibility requirements for ICF/MR level of care.

(b) The "comprehensive assessment reporting evaluation (CARE)" tool will determine your eligibility and amount of personal care services.

(c) If you are in the Basic, Basic Plus, CIIBS, or Core waiver, the DDD assessment will determine the amount of respite care available to you.

(2) From the assessment, DDD develops your waiver plan of care or individual support plan (ISP) with you and/or your legal representative and others who are involved in your life such as your parent or guardian, advocate and service providers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-3000, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-3000, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3085 What if my needs exceed what can be provided under the CIIBS, Core or Community Protection waiver? (1) If you are on the CIIBS, Core or Community Protection waiver and your assessed need for services exceeds the scope of services provided under your waiver, DDD will make the following efforts to meet your health and welfare needs:

(a) Identify more available natural supports;

(b) Initiate an exception to rule to access available nonwaiver services not included in the CIIBS, Core or Community Protection waiver other than natural supports;

(c) Offer you the opportunity to apply for an alternate waiver that has the services you need, subject to WAC 388-845-0045;

(d) Offer you placement in an ICF/MR.

(2) If none of the above options is successful in meeting your health and welfare needs, DDD may terminate your waiver eligibility.

(3) If you are terminated from a waiver, you will remain eligible for nonwaiver DDD services but access to state-only funded DDD services is limited by availability of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-3085, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3085, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4005 Can I appeal a denial of my request to be enrolled in a waiver? (1) If you are not enrolled in a waiver and your request to be enrolled in a waiver is denied, your appeal rights are limited to the decision that you are not eligible to have your request documented in a statewide data base due to the following:

(a) You do not need ICF/MR level of care per WAC 388-845-0070, 388-828-8040 and 388-828-8060; or

(b) You requested enrollment in the CIIBS waiver and do not meet CIIBS eligibility per WAC 388-828-8500 through 388-828-8520.

(2) If you are enrolled in a waiver and your request to be enrolled in a different waiver is denied, your appeal rights are limited to the following:

(a) DDD's decision that the services contained in a different waiver are not necessary to meet your health and welfare needs and that the services available on your current waiver can meet your health and welfare needs; or

(b) DDD's decision that you are not eligible to have your request documented in a statewide database because you requested enrollment in the CIIBS waiver and do not meet CIIBS eligibility per WAC 388-828-8500 through 388-828-8520.

(3) If DDD determines that the services offered in a different waiver are necessary to meet your health and welfare needs, but there is not capacity on the different waiver, you do not have the right to appeal any denial of enrollment on a different waiver when DDD determines there is not capacity to enroll you on a different waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 2009 c 194, and 2008 c 329 § 205 (1)(i), and Title 71A RCW. 10-22-088, § 388-845-4005, filed 11/1/10, effective 12/2/10. Statutory Authority: RCW 71A.12.030, 71A.12.-120 and Title 71A RCW. 07-20-050, § 388-845-4005, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.-120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4005, filed 12/13/05, effective 1/13/06.]

Chapter 388-850 WAC

COUNTY PLAN FOR DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-25 WAC)

WAC

388-850-045 What is the formula for distribution of funding to the counties?

WAC 388-850-045 What is the formula for distribution of funding to the counties? (1) For the purposes of this section, "county" shall mean the legal subdivision of the state, regardless of any agreement with another county to provide developmental disabilities services jointly.

(2) The allocation of funds to counties shall be based on the following criteria:

(a) The distribution of funds provided by the legislature or other sources shall be based on a distribution formula which best meets the needs of the population to be served.

(b) The distribution formula takes into consideration requirements of clients residing in an ICF/MR or clients on one of the division's Title XIX home and community-based waivers, the number of children eligible for birth to three services, special education enrollment, the number of individuals receiving county funded services, the number of individuals enrolled with the division and the general population of the county.

(c) The ability of the community to provide funds for the developmental disability program provided in chapter 71A.14 RCW may be considered with any or all of the above.

(3) A county may utilize seven or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than seven percent for county administration with approval of the division director.

[Statutory Authority: RCW 71A.12.030, 71A.12.020, 2009 c 564 § 205 (1)(n), and chapter 34.05 RCW. 10-13-164, § 388-850-045, filed 6/23/10, effective 7/24/10. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-850-045, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-850-045, filed 12/29/03, effective 1/29/04. 99-19-104, recodified as § 388-850-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.040. 92-13-032 (Order 3404), § 275-25-530, filed 6/10/92, effective 7/11/92. Statutory Authority: RCW 71A.14.030. 91-17-005 and 91-17-025 (Orders 3230 and 3230A), § 275-25-530, filed 8/9/91 and 8/14/91, effective 9/9/91 and 9/14/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-530, filed 1/12/83; Order 1142, § 275-25-530, filed 8/12/76.]

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC

388-865-0420 Intake evaluation.
388-865-0425 Individual service plan.
388-865-0430 Clinical record.

WAC 388-865-0420 Intake evaluation. (1) All individuals receiving community mental health outpatient services, with the exception of crisis, stabilization, and rehabilitation case management services, must have an intake evaluation. The purpose of an intake evaluation is to gather information to determine if a mental illness exists which is a covered diagnosis under Washington state's section 1915(b) capitated waiver program, and if there are medically necessary state plan services to address the individual's needs. (For a listing of the covered diagnoses and state plan services go to: http://www.dshs.wa.gov/pdf/hrsa/mh/Waiver_2008_2010_PIHP_NEW_%200408_with_final_revisions.pdf)

(2) The intake evaluation must:

(a) Be provided by a mental health professional.

(b) Be initiated within ten working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the initiation of the intake.

(c) Be culturally and age relevant.

(d) Document sufficient information to demonstrate medical necessity as defined in the state plan, and must include:

(i) Presenting problem(s) as described by the individual, including a review of any documentation of a mental health condition provided by the individual. It must be inclusive of people who provide active support to the individual, if the individual so requests, or if the individual is under thirteen years of age;

(ii) Current physical health status, including any medications the individual is taking;

(iii) Current substance use and abuse and treatment status (GAIN-SS);

(iv) Sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM IV TR) criteria, or its successor;

(v) An identification of risk of harm to self and others, including suicide/homicide. Note: A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, must be made if indicated in the risk assessment;

(vi) Whether they are under the supervision of the department of corrections; and

(vii) A recommendation of a course of treatment.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), and 71.34.380. 10-09-061, § 388-865-0420, filed 4/19/10, effective 5/20/10. Statutory Authority: RCW 71.24.035. 07-06-050, § 388-865-0420, filed 3/2/07, effective 4/2/07. Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0420, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0420, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0425 Individual service plan. The community mental health agency must develop a consumer-driven, strength-based individual service plan that meets the individual's unique mental health needs. The individual service plan must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable. The service plan must:

(1) Be initiated with at least one goal identified by the individual, or their parent or other legal representative if applicable, at the intake evaluation or the first session following the intake evaluation.

(2) Be developed within thirty days from the first session following the intake evaluation.

(3) Address age, cultural, or disability issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment.

(4) Include treatment goals or objectives that are measurable and that allow the provider and individual to evaluate progress toward the individual's identified recovery goals.

(5) Be in language and terminology that is understandable to individuals and their family.

(6) Identify medically necessary service modalities, mutually agreed upon by the individual and provider, for this treatment episode.

(7) Demonstrate the individual's participation in the development of the individual service plan. Participation may be demonstrated by the individual's signature and/or quotes documented in the plan. Participation must include family or significant others as requested by the individual. If the provider developing the plan is not a mental health professional, the plan must also document approval by a mental health professional.

(8) Include documentation that the individual service plan was reviewed at least every one hundred eighty days. It should also be updated to reflect any changes in the individual's treatment needs or as requested by the individual, or their parent or other legal representative if applicable.

(9) With the individual's consent, or their parent or other legal representative if applicable, coordinate with any systems or organizations the individual identifies as being relevant to the individual's treatment. This includes coordination with any individualized family service plan (IFSP) when serving children under three years of age.

(10) If an individual disagrees with specific treatment recommendations or is denied a requested treatment service, they may pursue their rights under WAC 388-865-0255.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), and 71.34.380. 10-09-061, § 388-865-0425, filed 4/19/10, effective 5/20/10. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0425, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0430 Clinical record. The licensed community mental health agency must maintain a clinical record for each individual served in a manner consistent with WAC 388-865-0435, 388-865-0436, or any successors. The clinical record must contain:

(1) An intake evaluation;

(2) Evidence that the consumer rights statement was provided to the individual, or their parent or other legal representative if applicable;

(3) Documentation that the provider requested a copy of and inserted into the clinical record if provided, any of the following:

(a) Mental health advance directives;

(b) Medical advance directives;

(c) Powers of attorney;

(d) Letters of guardianship, parenting plans and/or court order for custody;

(e) Least restrictive alternative order(s);

(f) Discharge summaries and/or evaluations stemming from outpatient or inpatient mental health services received within the last five years, when available.

(4) Any crisis plan that has been developed;

(5) The individual service plan and all revisions to the plan;

(6) Documentation that services are provided by or under the clinical supervision of a mental health professional;

(7) Documentation of any clinical consultation or oversight provided by a mental health specialist;

(8) Documentation of:

(a) All service encounters;

(b) Objective progress toward established goals as outlined in the treatment plan; and

(c) How any major changes in the individual's circumstances were addressed.

(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred;

(10) Documentation that the department of corrections was notified by the provider when an individual on a less restrictive alternative or department of corrections order for mental health treatment informs the provider that the individual is under supervision by the department of corrections. Notification can be either written or oral. If oral notification, it must be confirmed by a written notice, including e-mail and fax. The disclosure to department of corrections does not require the person's consent.

(a) If the individual has been given relief from disclosure by the committing court, the individual must provide a copy of the court order to the treating community mental health agency (CMHA).

(b) There must be documentation that an evaluation by a designated mental health professional (DMHP) was requested in the following circumstance:

(i) The mental health provider becomes aware of a violation of the court-ordered treatment of an individual when the violation concerns public safety; and

(ii) The individual's treatment is a less restrictive alternative and the individual is being supervised by the department of corrections.

(11) Either documentation of informed consent to treatment by the individual or parent or other legal representative or if treatment is court ordered, a copy of the detention or involuntary treatment order;

(12) Documentation that the individual, or their parent or other legal representative if applicable, are informed about the benefits and possible side effects of any medications prescribed for the individual in language that is understandable;

(13) Documentation of confidential information that has been released without the consent of the individual under the provisions in RCW 70.02.050, 71.05.390, 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA);

(14) For individuals receiving community support services, the following information must be requested from the individual and the responses documented:

(a) The name of any current primary medical care provider;

(b) Any current physical health concerns;

(c) Current medications and any related concerns;

(d) History of any substance use/abuse and treatment;

(e) Any disabilities or special needs;

(f) Any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition; and

(g) Information about past or current trauma and abuse.

(15) A description of the individual's strengths and resources; and

(16) A description of the individual's self-identified culture.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), and 71.34.380. 10-09-061, § 388-865-0430, filed 4/19/10, effective 5/20/10. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0430, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0430, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0430, filed 5/31/01, effective 7/1/01.]

Chapter 388-880 WAC

SPECIAL COMMITMENT—SEXUALLY VIOLENT PREDATORS

(Formerly chapter 275-155 WAC)

WAC

388-880-005	Special commitment of sexually violent predators—Legal basis.
388-880-007	Purpose.
388-880-010	Definitions.
388-880-030	Sexual predator program supplemental and post commitment evaluations.
388-880-031	Sexual predator program annual evaluation.
388-880-033	Evaluator—Qualifications.
388-880-034	Evaluator—Supplemental and post commitment evaluation responsibilities.

388-880-035 Refusal to participate in a supplemental or post commitment pretrial evaluation.
388-880-036 Supplemental evaluation—Reporting.
388-880-040 Individualized treatment.
388-880-042 Resident records—Purposes.
388-880-043 Resident records—Location and custody.
388-880-044 Resident records—Access.
388-880-045 Resident records—Retention.
388-880-050 Rights of a person court-detained or civilly committed to the special commitment center.
388-880-055 How SCC processes recommendations related to releases, discharges and revocations.
388-880-056 How SCC considers a resident for release to an LRA.
388-880-057 How SCC considers a resident's revocation of LRA status.
388-880-058 How SCC considers a recommendation for a resident's unconditional discharge.
388-880-059 Communicating and coordinating resident discharge and conditional release related matters.
388-880-060 Sexual predator program reimbursement.
388-880-070 Resident escorted leave—Purpose.
388-880-080 Reasons why escorted leave is allowed.
388-880-090 Conditions of a resident's escorted leave.
388-880-100 Application requests and approval for resident escorted leave.
388-880-110 Procedures for resident escorted leave.
388-880-120 Expenses associated with escorted leave.
388-880-130 Escorted leave expenses—Paid by resident.
388-880-140 Escorted leave expenses—Paid by department.
388-880-150 Requests for public disclosure.
388-880-151 Requests for resident medical information.

WAC 388-880-005 Special commitment of sexually violent predators—Legal basis. (1) Chapter 71.09 RCW authorizes the department to develop a sexual predator program (SPP) for a person the court determines to be a sexually violent predator.

(2) The department's SPP shall provide:

(a) Custody, supervision, and evaluation of a person court-detained to the SPP to determine if the person meets the definition of a sexually violent predator under chapter 71.09 RCW; and

(b) Treatment, care, evaluation and control of a person civilly committed as a sexually violent predator.

(3) Evaluations and evaluation procedures may be established in coordination with the department, the department of corrections and the end of sentence review committee.

(4) Secure facilities operated by the department for the sexual predator program include the special commitment center (SCC) total confinement facility, a secure community transition facility, and any community-based facility established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

(5) The secretary or designee may execute such agreements as appropriate and necessary to implement this chapter.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-005, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-005, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-005, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-005, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-005, filed 8/21/90, effective 9/21/90.]

WAC 388-880-007 Purpose. These rules carry out the legislative intent of chapter 71.09 RCW, authorizing the department to provide evaluation, care, control, and treatment of persons court-detained or civilly committed to the sexual predator program.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-007, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-007, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-007, filed 12/27/01, effective 1/27/02.]

WAC 388-880-010 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

"Appropriate facility" means the total confinement facility the department uses to hold and evaluate a person court-detained under chapter 71.09 RCW.

"Authorized third party" means a person approved in writing by the resident on a DSHS Form 17-063 (Authorization to disclose records), who may request and have access to the resident clinical file under chapter 71.09 RCW or the resident's medical records under chapter 70.02 RCW.

"Care" means a service the department provides during a person's detention or commitment within a secure facility toward adequate health, shelter, and physical sustenance.

"Control" means a restraint, restriction, or confinement the department applies protecting a person from endangering self, others, or property during a period of custody under chapter 71.09 RCW.

"Department" means the department of social and health services.

"Escorted leave" means a leave of absence under the continuous supervision of an escort from a facility housing persons who are court-detained or civilly committed under chapter 71.09 RCW.

"Evaluation" means an examination, report, or recommendation by a professionally qualified person to determine if a person has a personality disorder and/or mental abnormality which renders the person likely to engage in predatory acts of sexual violence if not confined in a secure facility. The four types of evaluations that occur related to a person's commitment or detention under chapter 71.09 RCW are as follows:

• The **initial evaluation** occurs before the person is detained at the SCC, usually occurring while the person is in prison, juvenile rehabilitation administration (JRA), a state mental hospital, a county jail, or in the community following commission of a recent overt act.

• **Supplemental evaluations**, as required by RCW 71.09.040, are performed for civil commitment trial purposes.

• **Annual review evaluations** occur only after a person has been civilly committed under RCW 71.09.070

• **Post commitment evaluations**, as required by RCW 71.09.090, when the person qualifies for a conditional or unconditional release trial.

"Health care facility" means any hospital, hospice care center, licensed or certified health care facility, health maintenance organization regulated under chapter 48.46 RCW, federally qualified health maintenance organization, federally approved renal dialysis center or facility, or federally approved blood bank.

"Health care practitioner" means an individual or firm licensed or certified to engage actively in a regulated health profession.

"Health care services" means those services provided by health professionals licensed pursuant to RCW 18.120.-020(4).

"Health profession" means those licensed or regulated professions set forth in RCW 18.120.020(4).

"Immediate family" includes a resident's parents, stepparents, parent surrogates, legal guardians, grandparents, spouse, brothers, sisters, half or stepbrothers or sisters, children, stepchildren, registered domestic partner, and other dependents.

"Indigent" refers to the financial status of a resident who has maintained a total balance of forty dollars or less, combined, in his/her resident trust and resident store accounts for the past thirty days, after paying court ordered legal financial obligations, child support, or cost-of-care reimbursement, and who swears or affirms under penalty of perjury that he/she has no additional outside resources, including but not limited to pension income, business income, and a spouse's or registered domestic partner's employment or other income.

"Individual treatment plan (ITP)" means an outline the SCC staff persons develop detailing how control, care, and treatment services are provided to a civilly committed person or to a court-detained person.

"Legal mail" means a resident's written communications, to or from: Courts/court staff regarding a legal action currently before a court, a licensed attorney, a public defense agency, a licensed private investigator retained by private counsel representing a resident or appointed by a court, an expert retained by an attorney representing a resident or appointed by a court, and a law enforcement agency.

"Less restrictive alternative" means court-ordered treatment in a setting less restrictive than total confinement which satisfies the conditions stated in RCW 71.09.092. A less restrictive alternative may not include placement in the community protection program as pursuant to RCW 71A.12.-230.

"Less restrictive alternative facility" means a secure community transition facility as defined under RCW 71.09.-020(1).

"Mental abnormality" means a congenital or acquired condition affecting the person's emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others.

"Native format" means the format in which a record subject to public disclosure was originally produced.

"Oversight" means official direction, guidance, review, inspection, investigation, and information gathering activities conducted for the purposes of program quality assurance by persons or entities within, or external to, the SCC.

"Personality disorder" means an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has onset in adolescence or early adulthood, is stable over time and leads to distress or impairment. Purported evidence of a personality disorder must be supported by testimony of a licensed forensic psychologist or psychiatrist.

"Predatory" means acts a person directs toward:

(1) Strangers;

(2) Individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or

(3) Persons of casual acquaintance with whom no substantial personal relationship exists.

"Professionally qualified person":

(1) **"Psychiatrist"** means a person licensed as a physician in this state, in accordance with chapters 18.71 and 18.57 RCW. In addition, the person shall:

(a) Have completed three years of graduate training in a psychiatry program approved by the American Medical Association or the American Osteopathic Association; and

(b) Be certified, or eligible to be certified, by the American Board of Psychiatry and Neurology.

(2) **"Psychologist"** means a person licensed as a doctoral level psychologist in this state, in accordance with chapter 18.83 RCW.

"Relapse prevention plan (RPP)" details static and dynamic risk factors particular to the resident and contains a written plan of interventions for the purpose of reducing the risk of sexual offending.

"Resident" means a person court-detained or civilly committed pursuant to chapter 71.09 RCW.

"Resident trust account" means the custodial bank account, held by the state, which represents the resources of the individual resident which is held for the individual resident's use.

"Responsivity" refers to the delivery of treatment in a manner that is consistent with the abilities and learning style of the offender. Responsivity can be conceptualized within the following categories: Physical limitations and sensory impairments, cognitive and learning impairments, mental health symptoms and behavioral disorders, cultural and subcultural differences to the extent that these differences may interfere with treatment participation.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"Secure community transition facility (SCTF)" means a residential facility for persons civilly committed and conditionally released to a less restrictive alternative under chapter 71.09 RCW. A secure community transition facility has supervision and security, and either provides or ensures the provision of sex offender treatment services. Secure community transition facilities include, but are not limited to, the facilities established in RCW 71.09.201 and any community-based facilities established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

"SCTF community transition team (CTT-SCTF)" means a team made up of three key individuals who will be closely involved with day to day decision making related to the transition activities of a resident residing in an SCTF operated by the department of social and health services. These three individuals include the DOC community corrections officer, the sex offender treatment provider employed by the department or who has been contracted by SCC, and the SCTF manager, the clinical director or designee may substitute for the SCTF manager. The CTT-SCTF must approve all community activities of an SCTF resident. As the agency responsible for funding SCTF activities, the department

through its SCTF manager may consider budgetary constraints when approving or supporting discretionary activities such as community shopping or recreation, or personal activities such as visiting family and friends.

"Secure facility" means a residential facility for persons court-detained or civilly committed under the provisions of chapter 71.09 RCW that includes security measures sufficient to protect the community. Such facilities include total confinement facilities, secure community transition facilities, and any residence used as a court-ordered placement in RCW 71.09.096.

"Senior clinical team" means a body of clinical professionals as described below which has been designated by the superintendent to meet regularly to:

• Make decisions about the implementation of the sex offender treatment program.

• Review for the purposes of approval or denial, treatment team recommendations for phase promotions or demotions.

• Make clinical recommendations about residents in community less restrictive alternative (LRA) settings.

• Provide general consultation regarding resident treatment and behavioral management issues.

• Conduct outreach to program areas of SCC including staffing and consultation of residents in sex offender treatment.

• As requested, provide guidance and advice to the clinical director, the superintendent and the treatment teams.

Members of the senior clinical team are expected to take into account all available relevant information, including contextual and situational factors, to make optimal, clinically supportable decisions.

The senior clinical team shall consist of a team of professionally qualified persons employed by the department which are designated by the superintendent. The team may include a SCC contracted community based psychologist with advanced forensic assessment and treatment expertise, and/or a contracted community-based psychiatrist with advanced expertise in forensic assessment and treatment.

The senior clinical team shall not include the following persons (unless needed at the request of the clinical director for consultation on a specific issue(s):

• The resident's attorney;

• The prosecuting agency;

• Any representative from DOC;

• Potential sex offender treatment providers (SOTPs) or community providers of any type who may treat the resident; or

• Any other party who may serve to financially gain from the resident's release.

"Sexual predator program" means a department-administered and operated program including the special commitment center (SCC) established for:

(1) A court-detained person's custody and evaluation; or

(2) Control, care, and treatment of a civilly committed person defined as a sexually violent predator under chapter 71.09 RCW.

"Sexually violent offense" means an act defined under chapter 9A.28 RCW, RCW 9.94A.030 and 71.09.020.

"Sexually violent predator" means any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

"Superintendent" means the person appointed by the secretary of the department to be responsible for the general operation, program, and facilities of the SCC.

"Total confinement facility" means a facility that provides supervision and sex offender treatment services in a total confinement setting. Total confinement facilities include the special commitment center and any similar facility designated as a secure facility by the secretary.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-010, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-010, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-010, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-010, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-010, filed 8/21/90, effective 9/21/90.]

WAC 388-880-030 Sexual predator program supplemental and post commitment evaluations. (1) When a court orders a person transferred to an appropriate facility for an evaluation as to whether the person is a sexually violent predator, pursuant to RCW 71.09.040(4), the department shall, before the scheduled commitment hearing or trial, provide an evaluation to the court. The evaluation must make a recommendation as to whether the person suffers from a mental abnormality or personality disorder that makes the person more likely than not to engage in predatory acts of sexual violence if not confined in a secure facility.

(2) Supplemental and post commitment evaluations must be conducted in accordance with the criteria set forth in WAC 388-880-033, and must be in the form required by and filed in accordance with WAC 388-880-034 and 388-880-036.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-030, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-030, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-030, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-030, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-030, filed 8/21/90, effective 9/21/90.]

WAC 388-880-031 Sexual predator program annual evaluation. (1) Annually or as required by court order, the department shall conduct an evaluation and examine the mental condition of each person civilly committed under chapter 71.09 RCW. The evaluation shall be conducted by a professionally qualified person designated by the secretary.

(2) Under RCW 71.09.070, the annual evaluation must include consideration of whether:

(a) The person currently meets the definition of a sexually violent predator; and

(b) Conditional release to a less restrictive alternative is in the best interest of the person and conditions can be imposed that would adequately protect the community.

(3) The report of the department shall be in the form of a declaration or certification in compliance with the requirements of RCW 9A.72.085 and shall be prepared by a professionally qualified person as defined herein.

(4) The department shall file this periodic report with the court that civilly committed the person under chapter 71.09 RCW.

(5) A copy of this report shall be served on the prosecuting agency involved in the initial hearing or commitment and upon the detained or committed person and his or her counsel.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-031, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-031, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-031, filed 12/27/01, effective 1/27/02.]

WAC 388-880-033 Evaluator—Qualifications. Professionally qualified persons employed by the department or under contract to provide evaluative services must:

(1) Have demonstrated expertise in conducting evaluations of sex offenders, including diagnosis and assessment of reoffense risk;

(2) Have demonstrated expertise in providing expert testimony related to sex offenders or other forensic topics; and

(3) Provide documentation of such qualification to the department.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-033, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-033, filed 11/10/03, effective 12/11/03.]

WAC 388-880-034 Evaluator—Supplemental and post commitment evaluation responsibilities. The evaluation done in accordance with WAC 388-880-030(1) in preparation for a trial or hearing must be based on the following:

(1) Examination of the resident, including a forensic interview and a medical examination, if necessary;

(2) Review of the following types of records, tests or reports relating to the person that the evaluator deems necessary, including but not limited to:

(a) All available criminal records, to include arrests and convictions, and records of institutional custody, including city, county, state and federal jails or institutions, with any records and notes of statements made by the person regarding criminal offenses, whether or not the person was charged with or convicted of the offense;

(b) All necessary and relevant court documents;

(c) Sex offender treatment records and, when permitted by law, substance abuse treatment program records, including group notes, autobiographical notes, progress notes, psycho-social reports and other material relating to the person's participation in treatment;

(d) Psychological and psychiatric testing, diagnosis and treatment, and other clinical examinations, including records of custody in a mental health treatment hospital or other facility;

(e) Medical and physiological testing, including plethysmography and polygraphy;

(f) Any end of sentence review report, with information for all prior commitments upon which the report or reports were made;

(g) All other relevant and necessary records, evaluations, reports and other documents from state or local agencies;

(h) Other relevant and appropriate tests that are industry standard practices;

(i) All evaluations, treatment plans, examinations, forensic measures, charts, files, reports and other information made for or prepared by the SCC which relate to the resident's care, control, observation, and treatment.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-034, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-034, filed 11/10/03, effective 12/11/03.]

WAC 388-880-035 Refusal to participate in a supplemental or post commitment pretrial evaluation. If the person refuses to participate in examinations, forensic interviews, psychological testing, physiological testing, or any other interviews necessary to conduct the supplemental or post commitment evaluation under WAC 388-880-030(1), the evaluator must notify the SCC forensic services manager. The SCC will notify the prosecuting agency for potential court enforcement.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-035, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-035, filed 11/10/03, effective 12/11/03.]

WAC 388-880-036 Supplemental evaluation—Reporting. (1) The evaluation must be in the form of a declaration or certification in compliance with the requirements of RCW 9A.72.085 and must be prepared by a professionally qualified person.

(2) The report of the evaluation must include:

(a) A description of the nature of the examination;

(b) A diagnosis of the mental condition of the person;

(c) A determination of whether the person suffers from a mental abnormality or personality disorder;

(d) An opinion as to whether the person meets the definition of a sexually violent predator to a reasonable degree of psychological or medical certainty.

(3) The department shall file the evaluation with the court that detained or committed the person under chapter 71.09 RCW.

(4) A copy of the evaluation must be served on the prosecuting agency involved in the initial hearing or commitment, the court of record and upon the court-detained or civilly committed person and his or her counsel.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-036, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-036, filed 11/10/03, effective 12/11/03.]

WAC 388-880-040 Individualized treatment. (1) When the court detains a person or commits a person to the SCC, SCC staff persons designated by the clinical director shall develop an individual treatment plan (ITP) for the person. The resident shall have an opportunity to participate in the treatment planning process.

(2) The ITP shall be based upon, but not limited to, the following information as may be available:

(a) The person's offense history;

(b) A psycho-social history;

(c) The person's most recent evaluation; and

(d) A statement of high risk factors for potential reoffense, as may be ascertained over time.

(3) The ITP shall include, but not be limited to:

(a) A description of the person's specific treatment needs in:

(i) Sex offender specific treatment;

(ii) Substance abuse treatment, as applicable;

(iii) Supports to promote psychiatric stability, as applicable;

(iv) Supports for medical conditions and disability, as applicable;

(v) Social, family, and life skills.

(b) An outline of intermediate and long-range treatment goals, with cognitive and behavioral interventions for achieving the goals;

(c) A description of SCC staff persons' responsibilities; and

(d) A general plan and criteria, keyed to the resident's achievement of long-range treatment goals, for recommending to the court whether the person should be released to a less restrictive alternative.

(4) SCC staff persons shall review the person's ITP every six months.

(a) A new treatment plan will be issued every twelve months or more often as needed.

(b) Existing treatment plans will be reviewed at least once every six months by the treatment team, this review shall be documented in a progress note.

(c) The review or reissue of a resident's treatment plan may occur at anytime based on the resident's behavior or treatment status.

(5) A court-detained person's plan may include access to program services and opportunities available to persons who are civilly committed, with the exception that the court-detained person may be restricted in employment and other activities, depending on program resources and incentives reserved for persons who are civilly committed and/or actively involved in treatment.

(6) Nothing in this chapter shall exclude a court-detained person from engaging in the sex offender treatment program and, should the person elect to engage in treatment before the person's commitment trial:

(a) The person shall be accorded privileges and access to program services in a like manner as are accorded to a civilly committed person in treatment; and

(b) Shall not, solely by reason of the person's voluntary participation in treatment, be judged nor assumed by staff, administrators or professional persons of the SCC or of the department to meet the definition of a sexually violent predator under chapter 71.09 RCW.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-040, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-040, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-040, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-040, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-040, filed 8/21/90, effective 9/21/90.]

WAC 388-880-042 Resident records—Purposes. (1) The SCC shall maintain two types of records for each person court-detained for evaluation or civilly committed for treatment as a sexually violent predator. Such records shall be known as the clinical record and the medical record. Such records shall include:

(a) **Clinical records—**A record of mental health related treatment and behavior related matters such as:

(i) Evaluations, records, reports, and other documents obtained from other agencies relating to the person prior to the person's detention and/or commitment to the SCC.

(ii) Evaluations, clinical examinations, forensic measures, treatment plans charts, files, reports, responsive documents, grievances and other information made for or prepared by SCC personnel, contracted professionals, or others which relate to the person's care, control, and treatment during the person's detention or commitment to, the SCC.

(iii) Observation reports, memoranda to the resident, progress notes, behavior management reports, violation reports and other correspondence received at SCC or while on a secure community transition facility (SCTF) or other less restrictive alternative (LRA) placement.

(iv) Transitory and nontransitory documents will be retained pursuant to the DSHS approved retention schedule.

(b) **Medical records—**A record of medical care received by a resident before placement at SCC and while placed at SCC.

(i) All medical evaluations, records, reports, and other documents obtained from other agencies relating to the person's health status.

(ii) All medical evaluations, records, reports, and other documents created by SCC contracted and state personnel while the resident is placed at SCC.

(iii) Records made by contracted professional persons providing treatment or residential services may be maintained in their professional files, subject to contractual arrangement for SCC and department access to those records.

(iv) The SCC health clinic at the total confinement center on McNeil Island serves as the primary care provider and referring entity for all community based health care and treatment and as such is authorized to receive copies of all medical records pertaining to resident health care paid for by the department.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-042, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-042, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-042, filed 12/27/01, effective 1/27/02.]

WAC 388-880-043 Resident records—Location and custody. (1) Based on the resident's physical location of residence, his or her records shall be securely maintained in one of the following four types of locations:

(a) In a designated records storage area within the SCC total confinement facility (TCF);

(b) In a secure filing system at an SCC-operated secure community transition facility (SCTF);

(c) In a secure filing system at a contracted facility such as a group home or nursing home; or

(d) In a secure filing system of the office of a licensed, contracted provider such as a community based sex offender treatment provider or psychiatrist.

(2) The person's current medical and clinical treatment records shall be maintained in the facility wherein the resident is housed and made directly available to medical and emergency providers and authorized staff persons.

(3) The designated records storage area within the SCC TCF serves as a centralized repository for resident records regardless of the resident's status or location.

(4) During the period of a person's residence in a SCTF operated by the department:

(a) A copy of all resident records created at the SCTF will be forwarded to the SCC TCF records center, the original record will remain at the SCTF.

(b) The person's original records pertaining to their treatment, behavior and care while they resided at the SCC TCF will remain in the designated records storage area within the SCC TCF and will not be transferred to the SCTF.

(5) Regardless of location, only assigned treatment providers and authorized staff persons shall have access to resident records.

(6) During a period of a person's less restrictive alternative (LRA) placement in a private home or in a facility operated by a contracting agency:

(a) Original behavioral and treatment records and evaluations shall be maintained by the contracted professional providing treatment and copies thereof shall be sent to the SCC or the department by contract requirement; and

(b) Copies of documents held by the SCC may be made available as necessary to the contracting agency, the contracted treatment provider, and the assigned community corrections officer.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-043, filed 6/22/10, effective 7/23/10. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-043, filed 12/27/01, effective 1/27/02.]

WAC 388-880-044 Resident records—Access. (1) **Resident records disclosure requirements and conditions.**

(a) Per RCW 71.09.080, SCC must keep resident records detailing all medical, expert, and professional care and treatment received by an SCC resident, and must keep copies of all reports of periodic examinations made pursuant to the resident's detainment and/or civil commitment.

(b) Per RCW 71.09.080(2), access to resident medical and clinical records by persons other than department employees or parties representing the department is limited to the following:

(i) Upon request only to:

(A) The resident;

(B) The resident's attorney;

(C) The resident's legal guardian, guardian ad litem or other personal representative properly authorized, in writing, by the resident;

(D) The prosecuting attorney/attorney general;

(E) The court;

(F) A protection and advocacy agency when authorized by law; or

(G) An expert or professional person who, upon proper showing, demonstrates a need for access to such records.

(ii) Upon documented request by a resident, the SCC shall provide the resident supervised access to all clinical and medical records and reports, or to redacted copies thereof, related to the resident's commitment, control, care and treatment. SCC may reasonably limit conditions, frequency and duration of the resident's access to his or her records and reports.

(A) The resident must review the aforementioned documents in person, at the facility where he or she resides.

(B) The resident may purchase copies of these documents through the SCC public records disclosure process described in WAC 388-880-150.

(iii) All other parties requesting resident records must have the signed authorization of the resident or be the resident's personal representative, or obtain a court order. For these records, SCC will charge copying fees per WAC 388-880-150 and 388-880-151.

(2) **Inventories of resident personal property.**

(a) SCC is required by RCW 71.09.080(3) to make available for inspection, by a "responsible relative" of the resident, a copy of the resident's personal property inventory which has been signed by the staff members who conducted the inventory; unless the resident has specifically imposed a limitation on the release of this information in advance of the request.

(b) SCC will not disclose the contents of the inventory to other persons without authorization of the resident or order of the court.

(c) A copy of the resident's current inventory shall be provided to him or her at no cost whenever a new inventory has been completed.

(3) A policy on access to resident records shall be maintained and published to residents of the SCC.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-044, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-044, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-044, filed 12/27/01, effective 1/27/02.]

WAC 388-880-045 Resident records—Retention. (1) The SCC shall create schedules and requirements, consistent with department policy, for the retention, storage, and disposal of records, documents, evaluations, reports, and other material related to SCC residents, under the following conditions:

(a) While a person is currently court-detained or civilly committed to the SCC;

(b) Following a court ruling that a person does not meet the definition of a sexually violent predator within chapter 71.09 RCW and upon the person's release from the custody of the department;

(c) Following a resident's unconditional discharge from commitment;

(d) Following a resident's death.

(2) All original records specified herein and held by the SCC shall be retained in the SCC total confinement facility for a period of five years, after which the records will be transferred to a designated location for a period consistent with department administrative policy, after a resident's:

(a) Release following a court ruling that the person does not meet the definition of a sexually violent predator within chapter 71.09 RCW;

(b) Unconditional discharge from commitment; or

(c) Death.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-045, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-045, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-045, filed 12/27/01, effective 1/27/02.]

WAC 388-880-050 Rights of a person court-detained or civilly committed to the special commitment center. (1) During a person's period of detention or commitment, the department shall:

(a) Apprise the person of the person's right to an attorney and to retain one professionally qualified person to perform an evaluation on the person's behalf;

(b) Provide access to the person and the person's records in accordance with RCW 71.09.080 and WAC 388-880-044.

(2) A person the court detains for evaluation or commits to the SCC shall:

(a) Receive adequate care and individualized treatment;

(b) Be permitted to wear the person's own clothing except as may be required to wear state issued clothing during an escorted leave from the secure facility, or when the wearing of state issued clothing is required within the facility for health or safety of self or others, or when the wearing of a particular type of clothing or a particular colored clothing or accoutrement is prohibited for the general safety and security within the facility where the person is housed; and to keep and use the person's own possessions, except when deprivation of possessions is necessary for the person's protection, health or safety, the protection, health or safety of others, or to limit the quantity of the person's personal possessions to within facility limitation, or for the protection of property within the SCC or SCTF;

(c) Be permitted to accumulate and spend a reasonable amount of money in the person's SCC resident trust account;

(d) Have access to reasonable personal storage space within SCC limitations, which shall be outlined in an internal policy that is accessible to the person;

(e) Be permitted to have approved visitors within reasonable limitations;

(f) Have reasonable access to a telephone to make and receive confidential calls within SCC limitations; and

(g) Have reasonable access to letter writing material and to:

(i) Receive and send correspondence through the mail within SCC limitations and according to established safeguards against the receipt of contraband material; and

(ii) Send written communication regarding the fact of the person's detention or commitment.

(3) A person the court commits to the SCC shall have the following procedural rights to:

(a) Have reasonable access to an attorney and be informed of the name and address of the person's designated attorney;

(b) Petition the court for release from the SCC; and

(c) Receive annual written notice of the person's right to petition the committing court for release. The department's written notice and waiver shall:

(i) Include the option to voluntarily waive the right to petition the committing court for release; and

(ii) Annually be forwarded to the committing court by the department.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-050, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-050, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-050, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-050, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050. 93-17-027 (Order 3609), § 275-155-050, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-050, filed 8/21/90, effective 9/21/90.]

WAC 388-880-055 How SCC processes recommendations related to releases, discharges and revocations. The purpose of WAC 388-880-056 through 388-880-059 is:

(1) To explain how SCC internally considers residents for a release to an LRA;

(2) To explain how SCC internally considers a resident's revocation of LRA status;

(3) To explain how SCC internally considers a recommendation for a resident's unconditional discharge;

(4) To explain how SCC communicates and coordinates resident discharge and conditional release related matters.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-055, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-055, filed 11/10/03, effective 12/11/03.]

WAC 388-880-056 How SCC considers a resident for release to an LRA. When the department, based on a forensic evaluation or progress in sex offender treatment, considers a SCC resident for a less restrictive alternative placement under RCW 71.09.090(1), or considers a resident currently residing in a secure community transition facility (SCTF) on a conditional release for further transition into a nonSCTF less restrictive alternative, the clinical director shall schedule the senior clinical team to review the matter and formulate a clinical recommendation to the superintendent.

The meeting will provide an adequate staffing of the case, to include the resident's:

(1) Participation and progress in sex offender treatment.

(2) Behavior.

(3) Latest annual forensic evaluation.

(4) Relapse prevention plan.

(5) Any other relevant information such as: medication compliance, manifestation and management of dynamic risk factors, evidence or absence of paraphilia and personality disorder, responsivity, psychological testing, polygraph results, PPG assessments results, etc.

(6) When the resident is being considered for a LRA placement in a nonstate sponsored setting such as a private home or apartment option, the team shall also consider the resident's finances such as savings, benefits, eligibility for social services, housing options, employment or employability, absence or availability of community supports, family supports, etc.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-056, filed 6/22/10, effective 7/23/10.]

WAC 388-880-057 How SCC considers a resident's revocation of LRA status. (1) When a resident on a conditional release in any less restrictive alternative setting is alleged to have committed a violation of his or her court-ordered conditions and is pending a hearing on revocation or modification, the superintendent may direct a senior clinical team to review the matter and make a clinical recommendation.

(a) In developing its clinical recommendation, the senior clinical team will review:

(i) The resident's transition activity;

(ii) The factors surrounding the situation(s)/behavior(s) causing the revocation review;

(iii) The ability of SCC and DOC to adequately assure for the public's safety and the resident's compliance with less restrictive alternative conditions if the resident remains in the community or is allowed community access;

(iv) The ability of SCC and department of corrections (DOC) to adequately manage the resident in the community given existing resources; and

(v) Any other relevant information (e.g., medication compliance, manifestation and management of dynamic risk factors, evidence or absence of paraphilia and personality disorder, responsivity, psychological testing, polygraph results, PPG assessment results, etc.).

(b) The senior clinical team will provide the superintendent with a clinical recommendation regarding the revocation and any modification to the conditions if so recommended.

(2) The superintendent or designee will notify the prosecuting attorney, the resident's community corrections officer (CCO), sex offender treatment provider (SOTP) and local law enforcement of SCC's position pertaining to the revocation or continuation of the resident's less restrictive alternative status.

(3) When a resident is residing in the SCC total confinement facility while he or she is pending a revocation decision on their LRA status:

(a) An SCC associate superintendent will be responsible to determine the resident's living unit placement, behavior level assignment, persons who may be on the resident's personal visiting list, recreation activities and privileges, and personal property privileges.

(b) The resident's community transition team, in consultation with the SCC clinical department, shall determine the resident's treatment activities.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-057, filed 6/22/10, effective 7/23/10.]

WAC 388-880-058 How SCC considers a recommendation for a resident's unconditional discharge. (1) When the department, based on forensic evaluation that opines that a resident no longer meets the definition of a sexually violent predator, or based on progress in sex offender treatment and a successful transition process into the community, considers a resident for unconditional discharge, the clinical director shall convene a meeting of the senior clinical team within thirty days and provide a clinical recommendation to the superintendent.

(a) In formulating the clinical recommendation, the senior clinical team shall review any and all relevant information about this person, such as: Behavior, medication compliance, manifestation and management of dynamic risk factors, evidence or absence of paraphilia and personality disorder, responsivity, psychological testing, polygraph results, PPG assessment results, etc.

(b) The senior clinical team will provide the superintendent with a written statement identifying the clinical concerns of the team, if any.

(2) The superintendent or designee, after review of the forensic opinion and the clinical recommendation, will make a determination regarding the recommendation for the resident's unconditional discharge and will notify the relevant parties of the SCC position on the resident's unconditional discharge.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-058, filed 6/22/10, effective 7/23/10.]

WAC 388-880-059 Communicating and coordinating resident discharge and conditional release related matters. (1) **Communication with the department.**

(a) The SCC clinical director, or designee serves as the principal party at SCC responsible to communicate discharge and release matters internally within SCC.

(b) When a resident's request for advancement to community transition status is approved by the superintendent, the superintendent shall inform the DSHS secretary.

(c) If the SCC superintendent endorses the resident's request to petition the court for conditional release to either a secure community transition facility or other type of less restrictive alternative, the superintendent (as the secretary's designee) shall formally authorize the resident, in writing, to petition the court for a less restrictive alternative hearing in accordance with RCW 71.09.090.

(d) Once the superintendent has made a decision to support a resident's request to petition the court, the superintendent shall notify the clinical director of that decision. At that point the clinical director or designee shall serve as the principal party at SCC to communicate discharge and release matters to the resident, to external stakeholders which among others shall include the state attorney general's criminal justice division's sexually violent predator unit and the King County prosecuting attorney's sexually violent predator unit, and to organize the necessary activities in support of that discharge or conditional release.

(2) **Responsibility to communicate court related activities.**

(a) The resident's attorney is responsible to coordinate the court hearing.

(b) When the court orders a resident to be conditionally released to a less restrictive alternative, the SCC clinical director or designee shall:

(i) Manage the release process, including community notification to the appropriate law enforcement agency at least thirty days prior to the resident's release to the court-approved LRA.

(ii) Keep internal SCC stakeholders apprised of the status of the case.

(iii) Coordinate the transition with the:

(A) DOC end of sentence review committee program manager;

(B) Assigned DOC community corrections officer, if applicable;

(C) Court-approved sex offender treatment provider, if applicable;

(D) Appropriate SCTF manager, if applicable; and

(E) Other court-approved providers or persons for the resident's court-approved living setting.

(iv) The coordination will address civil commitment issues, community safety and the court-ordered conditions of release.

(3) **When the secretary objects to a pending release.**

When the DSHS secretary objects to a pending release under RCW 71.09.090, before the scheduled less restrictive

alternative court hearing or following the hearing such as in the case of newly discovered information, that objection shall be presented to the court in writing and shall be signed by the secretary or designee.

(4) **When a less restrictive alternative placement is approved by the court.**

When a resident of SCC is approved to transfer to a less restrictive alternative placement or a resident of a secure community transition facility is approved to transfer to an alternative less restrictive alternative placement, that placement will occur no sooner than thirty days following the day the court approves that placement. This thirty day period will allow SCC to fulfill its law enforcement notification obligations under RCW 9A.44.130 and the affected county sheriff to fulfill their public notification obligations under RCW 4.24.550.

(5) **When a resident is unconditionally released by the court.**

When a resident of the SCC total confinement facility or a secure community transition facility is determined by the court to no longer meet the criteria of a sexually violent predator under chapter 71.09 RCW, and the court orders that the resident shall be unconditionally released, SCC shall release the person within twenty-four hours of the court's decision.

(6) **When a resident or attorney proposes an alternative less restrictive alternative placement.**

(a) When a resident or attorney proposes an alternative less restrictive alternative placement other than what SCC recommends or supports, the resident or the attorney shall bear the responsibility to locate and identify that alternative.

(b) The department shall not reimburse attorneys or other parties for assisting residents in finding an alternative less restrictive alternative placement unless otherwise ordered by the commitment court for good cause.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-059, filed 6/22/10, effective 7/23/10.]

WAC 388-880-060 Sexual predator program reimbursement. (1) The department shall obtain reimbursement under RCW 43.20B.330, 43.20B.335, 43.20B.340, 43.20B.345, 43.20B.350, 43.20B.355, 43.20B.360, and 43.20B.370 for the cost of care of a person court-committed to a SPP to the extent of the person's ability to pay.

(2) The department shall calculate ability to pay and assess liability under WAC 388-855-0045 in order to permit the department to initiate cost of care collections.

(3) SCC shall fulfill its obligations under chapter 43.20 RCW by submitting relevant resident information on each resident who has been civilly committed under chapter 71.09 RCW to the DSHS office of financial recovery to determine the resident's ability to contribute to his or her cost of care.

(4) DSHS shall not reimburse attorneys for assisting residents in administrative hearings related to cost of care recovery actions by the department.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-060, filed 6/22/10, effective 7/23/10. Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-060, filed 11/10/03, effective 12/11/03. 99-21-001, recodified as § 388-880-060, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-060, filed 8/21/90, effective 9/21/90.]

WAC 388-880-070 Resident escorted leave—Purpose. The purpose of WAC 388-880-070 through 388-880-140 is:

(1) To set forth the conditions under which residents will be granted leaves of absence;

(2) To provide for safeguards to prevent escape, the obtaining of contraband, and the commission of new crimes, while on leaves of absence; and

(3) To outline the process for the reimbursement of the state by the resident and the resident's family for the costs of the leave of absence.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-070, filed 6/22/10, effective 7/23/10. 99-21-001, recodified as § 388-880-070, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-070, filed 12/1/97, effective 1/1/98.]

WAC 388-880-080 Reasons why escorted leave is allowed. An escorted leave of absence may be granted by the superintendent, or designee, subject to the approval of the secretary, to residents to:

(1) Go to the bedside of a member of the resident's immediate family as defined in WAC 388-855-0015, who is seriously ill;

(2) Attend the funeral of a member of the resident's immediate family as defined in WAC 388-855-0015; and

(3) Receive necessary medical or dental care which is not available in the institution.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-080, filed 6/22/10, effective 7/23/10. 99-21-001, recodified as § 388-880-080, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-080, filed 12/1/97, effective 1/1/98.]

WAC 388-880-090 Conditions of a resident's escorted leave. (1) An escorted leave shall be authorized only for trips within the boundaries of the state of Washington.

(2) The duration of an escorted leave to the bedside of a seriously ill member of the resident's immediate family or attendance at a funeral shall not exceed forty-eight hours unless otherwise approved by the superintendent, or designee.

(3) Other than when housed in a city or county jail or state institution the resident shall be in the visual or auditory contact of an approved escort at all times.

(4) The resident shall be housed in a city or county jail or state institution at all times when not in transit or actually engaged in the activity for which the escorted leave was granted.

(5) Unless indigent, the resident and immediate family member shall, in writing, make arrangements to reimburse the state for the cost of the leave prior to the date of the leave.

(6) The superintendent, or designee, shall notify county and city law enforcement agencies with jurisdiction in the area of the resident's destination before allowing any escorted leave of absence.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-090, filed 6/22/10, effective 7/23/10. 99-21-001, recodified as § 388-880-090, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-090, filed 12/1/97, effective 1/1/98.]

WAC 388-880-100 Application requests and approval for resident escorted leave. The superintendent,

or designee, shall establish a policy and procedures governing the method of handling the requests by individual residents. The superintendent, or designee, shall evaluate each leave request and, in writing, approve or deny the request within forty-eight hours of receiving the request based on:

(1) The nature and length of the escorted leave;

(2) The community risk associated with granting the request based on the resident's history of security or escape risk;

(3) The resident's overall history of stability, cooperative or disruptive behavior, and violence or other acting out behavior;

(4) The resident's degree of trustworthiness as demonstrated by his/her performance in unit assignments, security level, and general cooperativeness with facility staff;

(5) The resident's family's level of involvement and commitment to the escorted leave planning process;

(6) The rehabilitative or treatment benefits which could be gained by the resident; and

(7) Any other information as may be deemed relevant.

The resident's, and family's, ability to reimburse the state for the cost of the escorted leave shall not be a determining factor in approving or denying a request.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-100, filed 6/22/10, effective 7/23/10. 99-21-001, recodified as § 388-880-100, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-100, filed 12/1/97, effective 1/1/98.]

WAC 388-880-110 Procedures for resident escorted leave. (1) Only persons approved by the superintendent, or designee, will be authorized to serve as escorts. All escorts from the total confinement facility must be employees of either the department of social and health services or the department of corrections and must have attained permanent employee status. At least one of the escorts must be experienced in the escort procedures.

(2) The superintendent, or designee, shall determine the use and type of restraints necessary for each escorted leave on an individual basis.

(3) Escorted leaves supervised by department of corrections staff shall require the approval of the SCC superintendent, or designee, and be done in accordance with applicable department of corrections policy and procedures. The department of corrections shall be reimbursed, according to rates and procedures established between the department of social and health services and the department of corrections. Correctional officers may wear civilian clothing when escorting a resident for a bedside visit or a funeral.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-110, filed 6/22/10, effective 7/23/10. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-110, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-110, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-110, filed 12/1/97, effective 1/1/98.]

WAC 388-880-120 Expenses associated with escorted leave. (1) Staff assigned escort duties shall be authorized per diem reimbursement for meals, lodging, and transportation at the rate established by the state travel policy.

(2) Staff assigned escort duties, in a travel status, shall receive appropriate compensation at regular salary or overtime for all hours spent in actual escort of the resident, but not including hours spent sleeping or not engaged in direct supervision of the resident. The salary shall be paid at the appropriate straight time and overtime rates as provided in the civil service rules.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-120, filed 6/22/10, effective 7/23/10. 99-21-001, recodified as § 388-880-120, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-120, filed 12/1/97, effective 1/1/98.]

WAC 388-880-130 Escorted leave expenses—Paid by resident. (1) The expenses of the escorted leave as enumerated in WAC 388-880-070 through [388-880-]120 shall be reimbursed by the resident or his/her immediate family member unless the superintendent, or designee, has authorized payment at state expense in accordance with WAC 388-880-140.

(2) Payments by the resident, or the resident's immediate family member, shall be made to the facility's business office and applied to the appropriate fund as defined by law, applicable provisions of the Washington Administrative Code, or department policy.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-130, filed 6/22/10, effective 7/23/10. 99-21-001, recodified as § 388-880-130, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-130, filed 12/1/97, effective 1/1/98.]

WAC 388-880-140 Escorted leave expenses—Paid by department. The expenses of the escorted leave shall be absorbed by the state if:

(1) The resident and his/her immediate family are indigent as defined in WAC 388-855-0045; or

(2) The expenses were incurred to secure necessary medical or dental care.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-140, filed 6/22/10, effective 7/23/10. 99-21-001, recodified as § 388-880-140, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-140, filed 12/1/97, effective 1/1/98.]

WAC 388-880-150 Requests for public disclosure. (1) Public disclosure requests for SCC records.

SCC records may be requested under the Public Records Act providing that the request complies with requirements and limitations of chapter 42.56 RCW and the fulfillment of that request will not violate any of the disclosure exemptions and limitations found in state or federal law.

(a) A public records disclosure request should include:

(i) Requester's name;

(ii) Requester's address;

(iii) A clear statement on the first page of the request indicating that the request is asking for public records; and

(iv) Identification and specification of the records(s) wanted.

(b) The address and fax number for requesting SCC records under public disclosure is:

DSHS - Special Commitment Center
Attn: Public Disclosure Coordinator
PO Box 88450
Steilacoom, Washington 98388-0646

Or the request can be faxed to (253) 617-6318.

(2) **Public viewing of SCC records.**

Requesters may review requested SCC records instead of, or before purchasing, by:

(a) Requesting a viewing appointment through SCC public disclosure staff after receiving notice that the records are assembled.

(b) Attending the scheduled viewing appointment at the SCC administrative offices located at 1715 Lafayette Street in Steilacoom, Washington.

(c) Viewing hours are between 9:00 a.m. and 4:00 p.m., Monday through Friday, except on legal holidays.

(d) The requester may purchase copies of public records before or at the time of public viewing.

(e) The requester may designate another person to review the requested records at a viewing appointment as arranged through SCC public disclosure staff.

(f) If the requester or such other person as he designates does not appear to view an installment of records, the SCC no longer needs to complete processing of the request and the request is considered abandoned and complete.

(3) **Cost for making public disclosure copies of SCC records.**

Under the Public Disclosure Act, SCC charges a fee for making copies associated with a public disclosure request.

(a) Paper copy cost. The cost charged by SCC for copies of records under public records disclosure is fifteen cents per single-sided page or thirty cents for double-sided pages in the native format, plus the actual cost of the mailing container and postage.

(b) **Electronic copy cost.** PDF or TIFF type copies of SCC records may be provided when appropriate at the cost of fifty dollars per hour or thirteen cents per page, in the native format, plus cost of media, mailing container and postage. When charged an hourly rate, it shall be prorated based on the actual time used to scan the documents and transfer them to electronic media. Due to privacy and security concerns when exemptions apply to any part of the information provided, copies of electronic records must normally be provided in PDF or similar format.

(c) Other records. SCC charges fifty dollars per hour, prorated based on the actual time used, to make copies of videotapes and compact disks such as CDR and DVD formatted items, plus the cost of media, mailing container and postage.

(d) No party will be reimbursed for public record request costs made under chapter 388-885 WAC.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-150, filed 6/22/10, effective 7/23/10.]

WAC 388-880-151 Requests for resident medical information. (1) Requests for SCC resident medical information.

SCC medical records may be requested under chapter 70.02 RCW "health care records access and disclosure" by authorized third parties and will be charged at the rate provided below.

Note - requests for copies of medical records submitted by SCC residents on themselves, as covered under RCW 71.09.080, will be provided at the public disclosure rates provided in WAC 388-880-150.

(a) A health care records disclosure request from an authorized third party shall include:

(i) Requester's name;

(ii) Requester's address;

(iii) A copy of the written and signed authorization from the resident on a DSHS Form 17-063 (Authorization to Disclose Records);

(iv) A clear statement on the first page of the request indicating that the requester is asking for a specific resident's medical information; and

(v) Identification and specification of the medical records(s) wanted.

(b) Requests for resident medical records under chapter 70.02 RCW shall be made to the following address or fax number:

DSHS - Special Commitment Center
Attn: Public Disclosure Coordinator
PO Box 88450
Steilacoom, Washington 98388-0646

Or the request can be faxed to (253) 617-6318.

(2) **Cost for making copies of resident medical information.**

Under RCW 70.02.010(15) SCC charges a fee for making copies associated with a medical information request.

(a) Cost - regardless of format:

(i) No more than one dollar and two cents per page for the first thirty pages.

(ii) No more than seventy-eight cents per page for all additional pages.

(iii) A twenty-three dollar clerical fee may be charged for searching and handling records.

(iv) Cost of mailing container and postage.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 10-13-130, § 388-880-151, filed 6/22/10, effective 7/23/10.]